1992

Doyce Allen v. Utah Department of Health, Division of Health Care Financing : Brief of Appellant

Utah Supreme Court

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)CKET NO. 920197 IN THE SUPREME COURT, STATE OF UTAH

In Re: DOYCE ALLEN, Petitioner-Appellant, v. UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent-Appellee.	No. 920197 910287-CA 91-067-01 Category No. 14

BRIEF OF APPELLANT

This is an appeal from the "Final Agency Action and Order on Review" of the Utah Department of Health, Division of Health Care Financing, Rod Betit, Director, dated April 29, 1991, in Case No. 91-067-01 and the "Response to Request for Reconsideration" of the Utah Department of Health Care Financing, Rod Betit, Director, dated June 6, 1991, in Case No. 91-067-01, and from the decision of the Court of Appeals, affirming the agency's order. Allen v. Utah Dep't of Health, Div. of Health Care Fin., 829 P.2d 122 (Utah App. 1992).

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42 U.S.C. § 1396 (1992).

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JURISDICTION OF THE SUPREME COURT

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STATEMENT OF THE ISSUE

Whether the Utah Department of Health, Division of Health Care Financing ("Department"), erred in finding that Appellant could not "spend down" his assets to become eligible for Medicaid and whether the Court of Appeals erred in affirming this ruling?

STANDARD OF REVIEW

The standard of review is whether, on the basis of the agency's record, the Appellant has been substantially prejudiced by the agency's action. Utah Code Ann. § 63-46b-16(4) (1989); The correction-of-error standard of judicial review applies to

agency decisions involving issues of law and no deference is extended to agency rulings. Agency findings of fact are accorded substantial deference and will not be overturned, if they are based on substantial evidence. Hurley v. Industrial Commission, 767 P.2d 524, 527 (Utah 1988).

DETERMINATIVE CONSTITUTIONAL PROVISIONS, STATUTES, ORDINANCES AND RULES

42 C.F.R. § 435.840 (1990).

42 C.F.R. § 435.841 (1990).

42 U.S.C. § 1382b(2)(A) (1992)

42 U.S.C. § 1396 (1992).

42 U.S.C. § 1396a(a)(10)(c) (1992).

42 U.S.C. § 1396a(a)(17) (1992).

42 U.S.C. § 1396a(a)(34) (1992).

42 U.S.C. § 1396a(r) (1992).

(See Addendum for copies of these provisions.)

STATEMENT OF THE CASE

Nature of the Case

This is an appeal from a denial of Medicaid assistance dated February 19, 1991. Record, at 113 (hereinafter "R"). A prehearing conference was held on March 12, 1991. R. 108. A hearing was held on April 3, 1991. R. 97. Appellant, Doyce Allen (hereinafter "Allen") appeared in person and was not represented by counsel at his administrative hearing. R. 97.

Course of the Proceedings

On April 29, 1991, Allen, received an unfavorable "Final Agency Action and Order on Review," which found that Allen was over the asset limit for Medicaid coverage. R. 94-106. A "Response to Request for Reconsideration," dated June 6, 1991, upheld this decision. R. 78-80.

Disposition at Agency and Court of Appeals

Medicaid assistance having been denied at the agency level, an appeal to the Court of Appeals followed. R. 88-91. The Court of Appeals affirmed the ruling of the agency.

Relevant Facts with Citations to the Record

Allen was 64 years old at the time of the hearing. R. 7, 98. He was ineligible for Medicare because he was not 65 years of age. R. 9-10. He suffered a heart attack on January 23, 1991. R. 5.

Allen had worked for years at Intermountain Farmers and had been covered by Blue Cross/Blue Shield medical insurance. R. 98. After retirement Allen continued to receive this insurance coverage for eighteen months under "COBRA".[1] R. 34, 36. As the end of his period of COBRA coverage approached, Allen worked part-time at Intermountain Farmers to save up enough money to pay the necessary premiums to maintain his Blue Cross/Blue Shield insurance coverage beyond the COBRA period. R. 33-37.

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[1]Consolidated Omnibus Budget Reconciliation Act of 1985 which allows continuing private insurance coverage.

He filed an application for insurance with Blue Cross/Blue Shield. R. 33, 124-28. It is apparent from the fact that Allen saved this particular amount (i.e., the amount necessary to pay his insurance premium until he would be eligible for Medicare) and from the correspondence which accompanied his application that he fully expected to be given this continued coverage. See R. 33, 36, 37, 124. However, his application was denied on account of previous heart surgery. R. 5, 6, 33-34.

Allen appealed his denial but only succeeded in obtaining the names of additional insurance companies. R. 37. Allen contacted these companies but considered the price of any other insurance to be prohibitive. R. 37. It was apparent that the amount of money he had saved would not provide coverage for the desired period because of the high monthly premiums. See R. 33, 37. It also appeared that these other insurance company may have denied coverage regardless of the amount of the premium he would have been willing to pay. R. 98.

Allen went without coverage for approximately six months and was less than a year from his sixty-fifth birthday (when he would have become eligible for Medicare) at the time of his heart attack. See R. 5, 37, 101. He applied for Medicaid benefits on February 4, 1991. R. 11, 98.

Allen's Medicaid application included a request for retroactive benefits for January, 1991, to cover approximately $40,000.00 in medical bills resulting from his heart attack. R. 11-13, 98. By the time he was admitted to Utah Valley Regional

Medical Center for open-heart surgery, Allen was already obligated for $4,997.55 to Air Evac for air ambulance services rendered on January 26, 1991, in Phoenix, Arizona; $554.00 to Dr. Nudelman for critical care given on January 23-26, 1991; and, $9,649.10 to Havasu Samaritan Regional Hospital for hospitalization from January 23-26, 1991. R. 133-37, 140. Thereafter he incurred medical bills in the amounts of $304.50 to Valley Ambulance, Inc. for life flight on January 26, 1991; $1,495.00 to Dr. Frischknecht for hospital treatment from January 26-February 1, 1991; $1,872.00 for the anesthesiologist; $5,025.00 to Dr. Smith for treatment on January 27, 1991; $23,626.58 to Utah Valley Regional Medical Center for hospitalization from January 26, 1991 to February 1, 1991. R. 138-39, 141-44.

In order to qualify for Medicaid, Allen and his wife could not have assets in excess of $3,000.00. A review of their assets by the Medicaid office found that Allen and his wife held $3,029.00 in a savings account and $100.00 in a checking account as of the first moment of each of the months of January and February, 1991. R. 98. It was also found that Allen owned a 1983 Ford pick-up truck worth approximately $2,500.00, which could be excluded as exempt, a $600.00 Lincoln automobile and a $7,000.00 1981 travel trailer. R. 98.[2]

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[2]Allen's wife Lilly, age 62, is currently on Social Security Disability and requires continuous oxygen for chronic bronchitis, as well as trips to warmer climates during the winter time as a medical necessity. R. 6, 98, 114-23. When Mrs. Allen received her award certificate from the Social Security Administration,

Allen was denied Medicaid by the Office of Family Support, since his assets totaled $10,745.90. R. 113. Following a fair hearing, the Department affirmed the decision of the Office of Family Support, finding that Allen's savings account exceeded the limit. R. 99. The value ascribed to Allen's motor vehicles and travel trailer were not considered necessary to sustain a denial. R. 99.[3] However, it was argued and left undecided whether the truck and travel trailer could be excluded as medical necessities for Allen's wife. R. 52-59, 67-68, 98.

An issue was also raised as to whether the savings account fund was being held for burial expenses. R. 68-69. In Allen's will he had specifically listed the savings account as being for burial expenses. R. 82.

An additional issue was raised that Allen should have been allowed to "spend down" his assets in order to qualify for Medicaid. R. 130. At the hearing it was found that a spend down is only permitted with regard to income, not assets. R. 16-19. He also incurred many medical bills in January prior to his surgery, which he could have spent down to become eligible for Medicaid in February. R. 135-38, 140-44.

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for $7,844.00, she used it to purchase the travel trailer to travel to more suitable climates during the winter. R. 7-9, 114.

[3]. It appears that there is no "scope of service" problem and that Appellant's open-heart surgery would be paid for by Medicaid, if he were found eligible. R. 22.

SUMMARY OF THE ARGUMENT

Allen should have been permitted to spend down his assets so as to be eligible for medicaid. A resource spend down is necessary to fulfill the purpose of the medicaid program. Allowance of a 90-day retroactive application shows congressional intent to include a resource spend down. Federal law requires state medicaid plans to include reasonable standards and failure to include a resource spend down violates this requirement. An income spend down implies the adoption of a resource spend down.

ARGUMENT

THE DIRECTOR OF THE DIVISION OF HEALTH CARE FINANCING AND THE PRESIDING OFFICER FAILED TO DECIDE ALL OF THE ISSUES REQUIRING RESOLUTION--I.E., PETITIONER SHOULD HAVE BEEN ALLOWED TO SPEND DOWN HIS ASSETS SO AS TO QUALIFY FOR A MEDICAID CARD.

A. Overview of the Medicaid Program

Medicaid is a joint federal-state program designed to meet some of the medical needs of low-income persons. 42 U.S.C. § 1396 et seq. (1992); Schweiker v. Hogan, 457 U.S. 569, 571, 73 L.Ed 2d 227, 102 S.Ct. 2597, _____ (1982). States are not required to participate in the Medicaid program; however, once they choose to do so, they must comply with the Medicaid statute and implementing regulations. Schweiker v. Gray Panthers, 453 U.S. 34, 37, 69 L.Ed 2d 460, ___, 101 S.Ct. 2633, ____ (1981). A state participating in Medicaid must designate the state agency responsible for administering its program and must file a state plan with the federal agency stating, among other things, the coverage it intends to provide. 42 U.S.C. § 1396a(a)(5) (1992). The respondent in this case is the designated Utah Medicaid agency.

Eligibility for Medicaid is divided into two categories: categorically needy and the medically needy. 42 U.S.C. § 1396a (a)(10)(A)(i) & (ii) (1992). Those persons receiving Supplemental Security Income (SSI) or Aid to Families with Dependent children (AFDC) are considered categorically needy and the statute mandates that they receive Medicaid coverage. 42 U.S.C. § 1396 a(a)(10) (1992); 42 C.F.R. § 436.100 (1990). Under

the medically needy program, persons who would be considered disabled for SSI purposes but who have income and resources exceeding an established standard are permitted to incur bills which bring them within the set limits for eligibility. 42 U.S.C. § 1396a(a)(10)(C) (1992); 42 C.F.R. § 435.301 (1990). In determining Medicaid eligibility for a disabled person, a state participating in Medicaid must apply resource eligibility criteria which are no more restrictive than those applied in the SSI program. 42 U.S.C. § 1396 a(a)(10)(C)(III) (1992); 42 U.S.C. § 1396a(r) (1992); 42 C.F.R. §§ 435.301(a)(2), 435.840 & 435.841 (1990). In this case, the SSI resource criteria found at 20 C.F.R. §§ 416.1216 & 416.1218 (1990) are directly applicable. See addendum.

Utah has opted to participate in the Medicaid Program and has established the Division of Health Care Financing (DHCF) to implement, organize, administer and maintain the program. Utah Code Ann. §§ 26-18-2.1, 26-18-3 (1989 & Supp. 1991). As a condition for receipt of Medicaid funds, Utah submitted a State plan for the medical assistance program and agreed to administer the program in accordance with the provisions of the State plan, the requirements of Titles XI and XIX of the Social Security Act, and all applicable Federal regulations and other official issuances of the Department. Utah Administrative Code § R455-1-1 (1991). As part of its plan, Utah adopted a medically needy program. Utah Administrative Code § R455-1-17 (1991). Utah has promulgated some of its resource criteria in the Utah

Administrative Code § R810-304 (1991). A more complete and current version is published in Volume III of Utah's policies and procedures. The asset level for two persons applicable in this case is $3000.00. Utah Administrative Code § R810-304-403 (1991).

At the Court of Appeals, Allen argued that the Utah Department of Health, Division of Health Care Financing ("the Department"), erred in counting his savings account as an available asset. That issue was decided against him by the Court of Appeals and is not before this Court. However, the Department further erred in finding that Allen could not spend down his assets to become eligible for Medicaid. This is the sole issue before the Court.

B. DHCF was Required to Implement a Resource Spend Down in Order to Fulfill the Purpose of the Medicaid Program

The "spend down" concept is an integral part of a medically needy program. The federal statute, in setting out the requirements of an acceptable state plan provides, in part:

> (a) A State plan for medical assistance must
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> ....
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> (17) ... include reasonable standards ... for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are ... available to the applicant or recipient... (C) provide for reasonable evaluation of any such income or resources, and (D) ... provide for flexibility in this application of such standards with respect to income by taking into account ... the costs ... incurred for

> medical care or for any other type of remedial care recognized under State law.

42 U.S.C. § 1396a(a)(17) (1992).

Under subsection (17)(D), an income spend down must be applied. The argument for a resource spend down is based on the purpose of a medically needy program, which is to provide needed care to individuals while exempting certain asset levels.

There is no dispute between the parties that the purpose of the Medicaid program is to provide for the medical needs of those lacking the means to provide their own care. Thus, the Medicaid statute provides that its purpose is "to furnish....medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services..." 42 U.S.C. § 1396 (1992). By refusing to implement a resource spenddown in this case, DHCF defeats that purpose.

The parties are in agreement that a resource spenddown is permitted under the Medicaid statute but do not agree whether it is required in order to carry out the purpose of the Medically needy program. A number of courts that have considered this issue have concluded that a resource spend down is a necessary part of a medically needy program. In Haley v. Commissioner of Public Welfare, 476 N.E. 2d 572, 579 (Mass. 1985), the court concluded that a resource spend down was intended, since the legislature had provided that "up to $2000 of personal property" was exempt. The court concluded:

> The Department's policy of determining eligibility without the application of a resource spend down does not comply with the requirement that an individual be allowed to retain a certain level of resources. Id.

In Hession v. Illinois Dept. of Public Aid, 544 N.E. 2d 751, 757-58 (Ill. 1989), similar reasoning was applied. The court noted that Illinois had chosen to provide medically needy coverage and had exempted "at least $1500 in assets when determining Medicaid eligibility." Because of this expressed intent to preserve a certain level of assets for medically needy individuals, the court found that a failure to apply a resource spend down would defeat legislative intent. Finally, in Kempson v. North Carolina Dept. of Human Resources, 397 S.E. 2d 314, 318 (N.C. App. 1990), aff'd (by equally divided court), 403 S.E.2d 279 (N.C. 1991), use of a resource spend down was found to be required in order to carry out the purpose of North Carolina's medically needy program. Again, this conclusion was based on the fact that a medically needy program by definition protects a certain level of assets for persons who cannot afford their own medical care. See Westmiller by Hubbard v. Sullivan, 729 F.Supp. 260 (W.D. N.Y. 1990); Contra, Harrison v. Commissioner, 595 A.2d 1053 (Me 1991).

The Utah Court of Appeals majority panel mistakenly read these cases as requiring a "specific legislative directive" in order for a resource spend down to be applied.[4] Its attempt to

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[4] The Court of Appeals reads footnote 9 of Haley v. Commissioner far too broadly in concluding that the Illinois court "found a statute `explicitly' appl[ying] a resource spend down..." The Illinois statute concerned transfer of assets cases which are a less common category of cases. While suggestive of

resolve the issue by looking to the Utah Medical Assistance Act, Utah Code Annotated § 26-18-1 et. seq. (1989), to determine whether the Utah legislature had "adopted" a resource spend down was misguided. Such a focus is inappropriate and guaranteed to produce a fruitless result, since the Utah legislature, in enacting the Medical Assistance Act, was silent on the issue. Not only did the legislature not address resource spend down, it makes no mention of the medically needy program at all. The Court of Appeals majority panel's focusing on what it characterized as "a legislative concern for economy and efficiency in the Medicaid program" (Utah Code Annotated § 26-18-2.3(1) (1989) is misleading, since it bears no relationship to the specific question at issue. The general statement regarding the need for economy in administering the Medicaid program could apply to any aspect of the program and does not evidence any intent to preclude use of a resource spend down.

Rather than mentioning the medically needy program, the Medical Assistance Act simply creates the DHCF and delegates to it authority for carrying out the Medicaid program. Utah Code Annotated § 26-18-2.1 (1989). It is DHCF that then decides which optional programs it wishes to provide in the state of Utah. DHCF's discretion is not absolute, however, since the Utah legislature must annually budget the amount of state dollars to

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the need for a resource spend down, the Illinois statute did not expressly authorize this mechanism in all cases as the Court of Appeals seems to conclude.

be allocated to the Medicaid program. Should the Utah legislature wish to restrict the Medicaid program, it could refuse to allocate funds to optional programs such as medically needy. The legislature has approved of the medically needy program in recent years, despite increasing demands on the Medicaid budget. By continuing to fund the medically needy program, the Utah Legislature has unequivocally expressed its support of the purpose of the program: to provide medical care to needy individuals while allowing them to preserve a certain level of personal property.

It is DHCF which implements the medically needy program and expresses in published regulations the Federal requirement that certain assets are exempt. Utah Adm. Code § R810-304-411 (1991). Included in the exempt assets are the applicant's home, a burial space, a $1500.00 burial fund and up to $3000.00 in personal property for a couple such as the Allens. Implicit in the approval of the medically needy program by the Utah legislature is a statement that low income Utah citizens in need of medical care must be allowed to preserve at least these minimum asset levels. If the purpose of the medically needy program is to be carried out, a resource spenddown must be allowed.

C. The Allowing Of A 90-Day Retroactive Application Shows Congressional Intent to Include a Resource Spend Down

Congressional intent to include a resource spend down in the Medicaid Act is also found in the provision allowing retroactive

application to establish eligibility for the three months before the month of application. 42 U.S.C. § 1396a(a)(34) (1992); Utah Administrative Code § 455-1-11 (1991). By this provision, Congress intended to make medical assistance available to applicants who were unable to apply at the time they became ill, due to the severity of their illness or because of other factors. Those potentially eligible for medically needy coverage but who are unaware of the restriction on resource spend down, or who are unable to spend down in time, are denied coverage. As the court in Kempson, 397 S.E. 2d at 318 observed, "Medicaid applicants are blindsided by this eligibility requirement simply because it is so illogical." It is consistent with congressional intent to allow an applicant both the right and some time to spend down excess assets so as to become eligible for medical assistance.

If Allen had been informed of the spend down requirements before applying for Medicaid, he could have spent down his excess assets, prior to application, thereby making himself eligible for medical assistance. He was already obligated for over $15,000 of medical bills (far in excess of his non-exempt assets) by the time he arrived in Utah for open-heart surgery. R. 133-37, 140. However, in the present case, Allen was in no physical condition to spend down his assets prior to his release from the hospital, just as he was in no condition to apply for Medicaid prior to that time. The only fair way of resolving Allen's dilemma was to allow a retroactive spend down of his excess resources.

D. Federal Law Requires State Medicaid Plans to Include Reasonable Standards

Federal law requires state medicaid plans to "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which are consistent with the objectives of this title [42 U.S.C. §§ 1396 et seq. (1992)]." 42 U.S.C. § 1396a(a)(17) (1992). A standard for determining eligibility is not reasonable unless it includes the opportunity to offset excess resources against incurred medical expenses. See Sen. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Admin. News 1943, 2019 (states are not allowed to require the use of income or resources which would bring the individual's income below the amount set as the test of eligibility under the state plan because this would reduce the person below the level determined by the state as necessary for his maintenance). A person who is unable actually to spend down his assets would become liable to the full extent of his resources, including resources which Congress intended to be retained by the applicant.

In Haley the court said:

> The department's policy of determining eligibility without the application of a resource spend down does not comply with the requirement that an individual be allowed to retain a certain level of resources.

Haley, 476 N.E.2d at 579. See also Walter O. Boswell Hospital, Inc. v. Yavapai County, 714 P.2d 878, 881 (Ariz. 1986) (a case concerning a county health program, where the court analogized to

Medicaid law, interpreting the Medicaid Act under Haley as requiring a resource spend down in order to comply with the requirement that an individual be allowed to retain a reasonable level of both resources and income).

The Illinois Supreme Court, reached the same result in Hession:

> By failing to consider an individual's incurred medical expenses as well as his or her assets, the Department defeats the legislature's intent. Under the Department's policy, a Medicaid applicant possessing resources in excess of the asset disregard is found to be ineligible for medical assistance despite the fact that the applicant may have incurred medical expenses which far exceed his or her resources. Because the applicant is not eligible for assistance, he or she becomes personally responsible for paying these bills and is required to deplete the assets which the legislature intended to be disregarded.
>
> In contrast, by allowing an applicant to spend down the assets above the disregard with incurred medical expenses the applicant is entitled to Medicaid benefits once the medical expenses exceed the excess in assets. Thus an individual is allowed to retain a certain level of assets and is personally liable for his or her medical expenses only to the extent that his or her resources exceed permissible limits. Considering the legislature's intent that the medically needy be allowed to retain some of their assets, we conclude that the Department must employ resource spend down methodology when determining Medicaid eligibility for these individuals.

Hession, 544 N.E.2d at 758.

The Medicaid Act also requires a "reasonable evaluation" of resources for purposes of eligibility for medical assistance. 42 U.S.C. § 1396a(a)(17)(C) (1992). "[R]easonable evaluation" means that "the States will not . . . overvaluate income and resources which are available." Sen. Rep. No. 404, 89th Cong., 1st Sess.,

reprinted in 1965 U.S. Code Cong. & Admin. News 1943, 2018. Allen's medical expenses far exceed his resources. Failure to consider his excess medical expenses against his resources overvalues his resources and is unreasonable.

As stated in the dissenting opinion by Judge Bench, a policy not to allow a resource spend down is unreasonable "since eligibility is determined by when the medically needy applicant applies for benefits." Allen v. Utah Dept. of Health, 829 P.2d 122, 128-29 (Utah App. 1992) (Bench, J., dissenting). An applicant who is "savvy enough to spend down his or her assets before applying for medicaid would be eligible, while the applicant who applies for benefits before spending down is not eligible." Id. at 129. Therefore a resource spend down should be allowed before eligibility is determined. Id.

E. An Income Spend Down Implies the Adoption of a Resource Spend Down

A resource spend down is impliedly adopted in the existence of an income spend down. See 42 U.S.C. § 1396a(a)(17)(D) (1992) (income spend down recognized); Allen v. Utah Dept. of Health, 829 P.2d 122, 125 n.9 (Utah App. 1992) (cases recognizing an income spend down). This is because resources are merely income which continues to be "held on the first moment of a calendar month." Utah Administrative Code § 810-304-403.12 (1991). In other words, money which was income on December 31st becomes an asset the next day, on January 1st, if it is not spent prior to

that time. Under 42 U.S.C. § 1396a(a)(17)(D) (1992), such money would be eligible for a spend down on December 31st, as income. It is unreasonable to think that Congress intended the mere passage of time to make such money ineligible for a spend down. It is logical to assume that Congress intended an income spend down to cover "saved income" as well as current income. Otherwise people will be motivated not to save and not to invest their saved income in assets which, if they exceed the exempt assets, could arguably be used to decrease the government's burden of providing part of their health care.

CONCLUSION

The Court should reverse the decision of the Department and Court of Appeals. The case should be remanded for a finding that a resource spend down applies and that Allen should have been allowed to spend down his assets so as to become eligible for medicaid.

Dated this 30th day of July, 1992.

Steven Elmo Averett

UTAH LEGAL SERVICES, INC.
By Steven Elmo Averett

CERTIFICATE OF MAILING

I certify that four true and correct copies of the foregoing brief were sent, postage prepaid, to the following on the 30th day of July, 1992.

Douglas W. Springmeyer & R. Paul Van Dam
Office of Attorney General
Utah Department of Human Services
120 North 200 West, 4th Floor
P.O. box 45011
Salt Lake City, Utah 84145

DATED this 30th day of July, 1992.

A D D E N D U M

OFFICE OF FAMILY SUPPORT
150 EAST CENTER STREET

PROVO UT 84606

Utah — DHS —
Form 228-C Rev. 4

24 30

NOTICE OF DECISION

DEPARTMENT OF HUMAN SERVICES

CASE NUMBER: 0016871
MAILING DATE: 19FEB91

DOYCE ALLEN
689 CANYON DRIVE 3A1-1
SPRINGVILLE UT 84663

DENY - ASSETS EXCEED LIMITS

DEAR DOYCE ALLEN

YOUR APPLICATION FOR MEDICAL ASSISTANCE, RECEIVED ON FEBRUARY 04, 1991, HAS BEEN DENIED. THIS IS BECAUSE THE VALUE OF YOUR HOUSEHOLD'S TOTAL RESOURCES IS MORE THAN OUR POLICY ALLOWS.

YOUR RESOURCES	$10,745.90
RESOURCE LIMIT	$3,000.00

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CALL US AT 801 374 7800. COLLECT CALLS WILL BE ACCEPTED.

THIS ACTION IS BASED ON VOLUME IIIF, SECTIONS 503 AND 361, VOLUME IIID, SECTION 503, AND VOLUME IIIM, SECTION 502.

Norman H. Bangerter
Governor
Suzanne Dandoy, M.D., M.P.H.
Executive Director
Rod Betit
Director

State of Utah

DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

288 North 1460 West
P.O. Box 16580
Salt Lake City, Utah 84116-0580
(801) 538-6151

DOYCE ALLEN, Petitioner, v. UTAH DEPARTMENT OF HEALTH DIVISION OF HEALTH CARE FINANCING, Respondent.	)	FINAL AGENCY ACTION AND ORDER ON REVIEW Case No. 91-067-01

IF YOU ARE NOT SATISFIED WITH THIS DECISION, YOU MAY REQUEST A RECONSIDERATION FROM THE DIRECTOR OF HEALTH CARE FINANCING WITHIN TWENTY (20) DAYS AFTER THIS DECISION IS SIGNED. IF YOU WOULD LIKE TO APPEAL THIS DECISION, YOU MAY FILE A PETITION IN THE UTAH COURT OF APPEALS WITHIN THIRTY (30) DAYS AFTER THIS DECISION IS SIGNED. IF YOU DECIDE TO APPEAL, YOU ARE NOT REQUIRED TO ASK FOR A RECONSIDERATION FIRST, BUT YOU MAY DO SO IF YOU WISH. IF YOU HAVE QUESTIONS, CALL (801) 538-6151.

The enclosed Recommended Decision has been reviewed pursuant to Section 63-46b-12 Utah Code Ann. 1953, as amended, entitled "Agency Review - Procedure," and Department of Health Administrative Rule R454-14, entitled "Division of Health Care Financing Administrative Hearing Procedures for Medicaid/UMAP Applicants, Recipients, and Providers."

ISSUE

WAS THE OFFICE OF FAMILY SUPPORT (OFS) CORRECT IN ITS DETERMINATION THAT THE PETITIONER WAS OVER THE ASSET LIMIT?

FINDINGS OF FACT

The Findings of Fact entered by the presiding officer in Recommended Decision No. 91-067-01 are hereby incorporated by reference.

CONCLUSIONS OF LAW

The Conclusions of Law entered by the presiding officer in Recommended Decision No. 91-067-01 are hereby incorporated by reference.

DISPOSITION

WHEREFORE, Recommended Decision No. 91-067-01 is hereby AFFIRMED.

REASONS FOR THE DISPOSITION

The rules regarding asset limits are set forth in Assistance Payments Administration (APA) Volume III, Section 503. Section 503-1 states in relevant part:

> To be eligible for medical assistance, a client's countable assets must be less than the applicable asset limits....

Section 503-2 states in relevant part:

> Use assets held on the first moment of a calendar month to compute eligibility for that month. The case is ineligible for the entire month if countable assets exceed limits on the first moment of the month....

The table in Section 503-3 indicates that the Medicaid asset limit for a household of two individuals is $3,000.

In this case, the petitioner and his wife held over $3,000 in a savings account at the first moment of the month for the months of January and February, 1991. Therefore, the decision of OFS to deny Medicaid disability benefits because of excess assets was correct.

RIGHT TO JUDICIAL REVIEW

Within twenty (20) days after the date that this Final Agency Action and Order on Review is issued, you may file a written request for reconsideration with the Director of the Division of Health Care Financing. Any request for reconsideration must state the specific grounds upon which relief is requested. The filing of such a request is not a prerequisite for seeking judicial review.

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Final Agency Action and Order on Review or, if a request for reconsideration is filed and denied, within thirty (30) days of the denial for reconsideration. The petition shall be served upon the Director of Health Care Financing and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a waiver of any right to appeal the Final Agency Action and Order on Review.

A copy of this Final Agency Action and Order on Review shall be sent to Petitioner or his representative at the last known address by certified mail, return receipt requested.

DATED this 29th day of April, 1991

UTAH DEPARTMENT OF HEALTH
Suzanne Dandoy, Executive Director

BY: Rod Betit
Rod Betit, Director
Division of Health Care Financing
Her Designated and Authorized Representative

0414H/115-117

BEFORE THE UTAH DEPARTMENT OF HEALTH

DIVISION OF HEALTH CARE FINANCING

STATE OF UTAH

----------ooOoo----------

DOYCE ALLEN,	:	
Petitioner,	:	RECOMMENDED DECISION
vs.	:	
UTAH DEPARTMENT OF HEALTH,	:	CASE NO. 91-067-01
DIVISION OF HEALTH CARE FINANCING,	:	
Respondent.	:	

Pursuant to Rule R454-14 of the Utah Department of Health and the Utah Administrative Hearing Procedures Act, Section 63-46b-1 et seq., Utah Code Annotated, 1953 as amended, a formal administrative hearing for the above captioned case was held on the 3rd day of April, 1991, at the Office of Family Support located at 150 East Center Street, Provo, Utah, at 10:00 o'clock in the A.M., Cornelius W. Hyzer, Hearing Officer, presiding. The petitioner appeared in person. The Office of Family Support/Utah Medical Assistance Program ("UMAP") was represented by Jon Wood and Patti Richards. This hearing was scheduled verbally and without written notice. Neither party was represented by counsel.

ISSUE

WERE THE ASSETS OF THE PETITIONER ABOVE THE ASSET LIMIT FOR THE MONTHS OF JANUARY AND FEBRUARY, 1991?

The petitioner, Doyce Allen, age 64, and his wife, Lilly, have severe medical problems. She is receiving Social Security disability benefits for chronic bronchitis. She is on continuous oxygen for this disorder. She also has to be transported to a warmer climate in the winter time when an inversion takes place in the Utah County because of her condition. To accomplish this purpose, her husband, Doyce Allen, purchased a 1983 Ford pick-up truck and a travel trailer. They paid $8,000.00, for the travel trailer two years ago. He and his wife used the cash from her Social Security disability hearing to do that. The hearing process to obtain Social Security disability required them to go to the administrative law judge, and by the time benefits were granted, the retroactive benefits exceeded $8,000.00.

Doyce Allen worked at Intermountain Farmers Co-op for many years and was covered under Blue Cross/Blue Shield medical insurance. In 1990, he obtained a part-time job with his former employer and reapplied for Blue Cross/Blue Shield benefits. He was covered under COBRA benefits until July 1, 1990. A letter was sent by his employer with the application on June 15, 1990. Blue Cross/Blue Shield denied his application for benefits for medical insurance. He looked for other insurance and determined that it would cost between $400.00 or $500.00 a month for medical insurance, and therefore, he never applied. He testified at the hearing that an application to one of these other companies may have been denied regardless of the amount of the premium he would have been willing to pay.

In January, 1991, the petitioner suffered a heart attack and had heart-bypass surgery. This medical bill remains unpaid.

The petitioner applied for Medicaid benefits on February 4, 1991. His income was not evaluated, but at the hearing it was determined there would be a substantial spendown required in the range of $400.00 to 450.00. The asset limit for a family of two is $3,000.00, and the Office of Family Support determined that he exceeded that on the basis of his savings account alone. The savings account contained $3,029.86 throughout the month of January and up to February 6, 1991, at which time Mrs. Allen withdrew the entire balance of that account.

The petitioner was informed at the hearing that the rule for asset determination requires that the evaluation take place on the first moment of the first day of each month and, therefore, because the funds in his checking and savings account were in excess of $3,000.00, the case was properly denied. Considerable discussion was also entertained on the use of the truck and travel trailer for medical purposes, but the amount of the money in the savings account alone exceeded the limit, and therefore, the issue of medical necessity was moot.

FINDINGS OF FACT

1. The petitioner, Doyce Allen, age 64, and his wife Lilly, age 62, applied for Medicaid benefits on February 4, 1991.

2. The application of the petitioner included a request for retroactive benefits for January, 1991, to cover approximately $40,000.00 in medical bills incurred at Utah Valley Regional Medical Center for open-heart surgery.

3. Lilly Allen, the petitioner's wife, is currently on Social Security Disability and requires continuous oxygen for chronic bronchitis, as well as trips to warmer climates during the winter time as a medical necessity.

4. The petitioner and his wife held $3,029.00 in a savings account and approximately $100.00, in a checking account the first moment of each of the months of January and February, 1991.

5. The petitioner owns a 1983 Ford pick-up truck worth approximately $2,500.00, which could be excluded as exempt, a $600.00 Lincoln automobile and a $7,000.00, 1981 travel trailer.

CONCLUSIONS OF LAW

The assets of the petitioner and his spouse exceed the $3,000.00, asset limit as set forth in APA Volume IIID.

REASONS FOR PRESIDING OFFICER'S DECISION

The petitioner was unable to demonstrate his assets were below the asset limit *and, therefore, he failed to meet his burden of proof.* Many alternatives were explored to try to determine that a correct decision was made by the Office of Family Support. After careful review with the petitioner of regulations requiring that his assets be determined as of the first moment of each month, the petitioner understood that his savings account alone exceeded the limit. Therefore, the value ascribed to his motor vehicles and the travel trailer were not necessary to sustain a denial.

RECOMMENDED AGENCY ACTION

The decision of the Office of Family Support to deny Medicaid benefits because of excess assets is hereby AFFIRMED.

RIGHT TO REVIEW

This Recommended Decision will be automatically reviewed by the Department of Health, Division of Health Care Financing, prior to its release. Both the Recommended Decision and a Final Agency Action, which represent the results of that review, will be released simultaneously by the Department of Health, Division of Health Care Financing.

DATED this 17th day of April, 1991.

Cornelius W. Hyzer

CORNELIUS W. HYZER
HEARING OFFICER

EXHIBITS

The following exhibits were admitted into evidence:

RESPONDENT'S EXHIBIT #1	Medicaid application of the petitioner, Doyce Allen
RESPONDENT'S EXHIBIT #2	Checking account and savings account bank statements

Norman H Bangerter
Governor
Suzanne Dandoy, M D., M P H
Executive Director
Rod Betit
Director

State of Utah

DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FINANCING

288 North 1460 West
P O Box 16580
Salt Lake City Utah 84116-0580
(801) 538-6151

----------ooOoo----------

DOYCE ALLEN, Petitioner,	:	RESPONSE TO REQUEST FOR RECONSIDERATION
v.	:	
UTAH DEPARTMENT OF HEALTH, DIVISION OF HEALTH CARE FINANCING, Respondent.	:	Case No. 91-067-01

----------ooOoo----------

This request for Reconsideration has been reviewed pursuant to 63-46b-13 Utah Code Ann. 1953, as amended.

FACTS

The Facts set forth in Recommended Decision No. 91-067-01 are hereby incorporated by reference.

DISPOSITION

The above-captioned Request for Reconsideration is hereby DENIED.

REASONS FOR THE DISPOSITION

The petitioner, age 64, became uninsurable and had a heart attack on January 23, 1991, while visiting in Arizona. The petitioner and his wife had enough money to return to Utah for bypass surgery. Throughout January, 1991, and up to February 6, 1991, the petitioner and his wife had $3,029 in a savings account and approximately $100 in a checking account. After applying for Medicaid on February 4, 1991, the petitioner's wife immediately withdrew all the money in the savings account and closed the account. Medicaid regulations require that the assets of an applicant be examined at the first moment of the month to determine whether or not they exceed the asset limit. The asset limit for the type of Medicaid requested was $3,000.00, leaving excess assets

In addition to the excess assets in the checking and savings account, there were other potential excess assets---an unencumbered trailer home worth approximately $7,000.00, and an automobile worth $600.00. At the formal hearing, the petitioner contended that the trailer was a medical necessity. The hearing officer's Recommended Decision correctly denied the petitioner's claim solely on the amount of cash available to him, without reaching the medical necessity issue.

The Utah Medicaid Program is funded by a combination of state and federal funds. Unfortunately, federal regulations do not allow consideration of individual circumstances in the application of income and asset limits. A Medicaid agency must use a methodology for the treatment of resources that is uniform for all individuals in a covered group. When income eligibility is the issue, a Medicaid recipient may spenddown excess income each month to "buy" a medical card. However, no such provisions exists to reduce assets.

RIGHT TO JUDICIAL REVIEW

Judicial review may be secured by filing a petition in the Utah Court of Appeals within thirty (30) days of the issuance of this Response to Request for Reconsideration. The petition shall be served upon the Director of Health Care Financing, Utah Department of Health and shall state the specific grounds upon which review is sought. Failure to file such a petition within the 30-day time limit may constitute a wavier of any right to appeal this decision.

A copy of this Response to Request for Reconsideration shall be sent to the petitioner or his representative at the last known address by certified mail, return receipt requested.

DATED this 6th day of June, 1991

UTAH DEPARTMENT OF HEALTH
Suzanne Dandoy, Executive Director

By: Rod Betit

Rod Betit, Director
Division of Health Care Financing
Her Designated and Authorized Representative

0448H/43-44

No: 91-067-01

CERTIFICATE OF MAILING

I hereby certify that on the 6th day of June, 1991, I mailed a true and correct copy of the foregoing Response to Request for Reconsideration, postage prepaid, to the following parties:

Rod Betit, Director
Division of Health Care Financing
INTER OFFICE MAIL
Salt Lake City, Utah 84116

Doyce Allen
689 Canyon Drive
Springville, Utah 84663

Brian Farr
Office of the Attorney General
DHS, 4th Floor
INTER OFFICE MAIL

Bob Banta
DHS, Office of Family Support
INTER OFFICE MAIL

Stephanie Mallory
DHS, Administrative Hearings
INTER OFFICE MAIL

Jeanie LeBlanc, Medicaid Supervisor
DHS, Quality Control
INTER OFFICE MAIL

Mike O'Brien, Associate Regional Director
Office of Family Support
150 East Center Street
Provo, Utah 84606

Jon Wood, Supervisor
Office of Family Support
150 East Center Street
Provo, Utah 84606

Ginny Duncan

Ginny Duncan

0379H/26

IN THE UTAH COURT OF APPEALS

----ooOoo----

Doyce Allen, Petitioner, v. Utah Department of Health, Division of Health Care Financing, Respondent.	OPINION (For Publication) Case No. 910287-CA F I L E D (March 17, 1992)

Original Proceeding in this Court

Attorneys: Steven Elmo Averett, Provo, for Petitioner
R. Paul Van Dam and J. Steven Mikita, Salt Lake City, for Respondent

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Before Judges Bench, Billings, and Russon.

BILLINGS, Associate Presiding Judge:

Petitioner Doyce Allen (Allen) appeals from a final order of respondent Utah Department of Health, Division of Health Care Financing (DHCF) denying him Medicaid benefits. We affirm.

FACTS

On January 23, 1991, Allen suffered a heart attack while in Arizona. He was subsequently transported to Utah where he underwent heart bypass surgery, resulting in medical costs exceeding $40,000.00. At the time of his heart attack, Allen had no health insurance and was ineligible for Medicare assistance because he was not sixty-five years old.

Allen applied for Medicaid benefits on February 4, 1991, seeking retroactive coverage to include medical bills incident to his heart surgery in January, 1991. Utah Medicaid guidelines require that Allen's assets be less than $3,000.00, on the first of each calendar month, to qualify for medical assistance. In both January and February, Allen owned a savings account in the

amount of $3,029.86, a checking account in the amount of $100.00, a Lincoln automobile valued at approximately $600.00, a 1983 Ford pickup truck valued at approximately $2,500.00, and a 1981 travel trailer valued at approximately $7,000.00.

On February 19, 1991, the Office of Family Support denied Allen's Medicaid application, finding his resources exceeded the $3,000.00 limit. Allen requested a formal hearing, after which a DHCF hearing officer sustained the denial on the ground that Allen's "savings account alone exceeded the limit." On April 29, 1991, the DHCF issued a Final Agency Action and Order on Review, adopting the findings and conclusions of the hearing officer. Allen then filed a Request for Reconsideration which was denied.

On appeal, Allen alleges the DHCF erred in denying his Medicaid application because: (1) The savings account funds are designated for burial expenses and, thus, exempt from consideration for Medicaid eligibility; (2) the travel trailer, modified to accommodate his wife's disabilities, is a medical necessity or personal effect and, thus, exempt from consideration for Medicaid eligibility; and (3) he should have been permitted to "spend down" his assets, by applying them to medical bills, in order to become eligible for Medicaid.

I. THE SAVINGS ACCOUNT AS A BURIAL FUND

Allen contends that his $3,029.86 savings account should not be included for purposes of Medicaid eligibility because it is exempt as a burial fund.[1] In support of this claim, Allen points to a statement in his will directing that the savings account be used "to bury Doyce Allen and Lilly Allen." Allen alleges the will is properly before this court on appeal because it was submitted to the DHCF with his Request for Reconsideration. The DHCF responds that it is inappropriate for us to consider Allen's will as part of the record on review because it was never introduced as evidence at Allen's formal administrative hearing.

A review of the record reveals that a copy of Allen's will was first presented to the DHCF as an attachment to a letter from Allen's counsel, dated June 3, 1991, requesting a transcript of

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1. Under the Utah Administrative Code, "a $1,500 burial or funeral fund exemption for each eligible household member" is permitted only if these funds "are separately identified and not commingled with other funds. They must be clearly designated so that an outside observer can see that these funds are specifically for the client's burial expense." Utah Code Admin. P. R810-304-411(9)(e)(1) (1991).

Allen's administrative hearing. The DHCF did not receive the will until June 10, 1991[2], after the hearing officer's Recommended Decision, the DHCF's Final Agency Action and Order on Review, and the DHCF's Response to Request for Reconsideration had already been signed and dated. Because there is no indication that Allen's will was ever included as evidence before the DHCF, it is not properly a part of Allen's record on appeal.

However, even if we were to consider the general language in Allen's will, the result would not be different. Allen clearly and unequivocally testified the account was to pay for insurance premiums, not burial expenses. Allen did not specify the account as a burial fund on his original Medicaid application. During his formal administrative hearing, Allen did not argue or present any evidence indicating his savings account was designated for burial expenses. In fact, when the hearing officer specifically asked if the savings account might be a burial fund, Allen replied that "we earned it last summer for our insurance premiums, and they didn't go through, so we had this money for a nest egg, you might say. You have to have a little bit of something in case--."[3] Therefore, considering only the savings

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2. Allen argues the will "was submitted at a time when the record was still open," pointing out that the letter to which the will was attached was mailed on June 3, 1991. The letter, nevertheless, clearly bears a "Received June 10, 1991" stamp.

3. Allen testified that, after the DHCF denied Medicaid benefits, Allen, in fact, did not maintain the account as a burial fund. The following exchange occurred at the administrative hearing:

> HEARING OFFICER: What did you do with the $3,000 in February which you pulled out of the savings account?
> MR. ALLEN: Well, we paid bills that was accrued during our heart attack deal here, and transportation to and from.
> HEARING OFFICER: So, that money was spent on medical things?
> MR. ALLEN: Bills again.

Contrary to his argument, Allen apparently neither considered nor used the savings account as a fund "separately identifiable" which was set aside "specifically" for burial expenses.

account for purposes of affirming on appeal[4], Allen's savings account alone surpassed the $3,000.00 Medicaid limit.

II. MEDICAID "SPEND DOWN"

A. An Overview of the Medicaid Program

Allen alternatively argues that he should have been permitted to spend his assets on medical bills in order to qualify for Medicaid. We look to both federal and Utah Medicaid regulations to resolve this question.

In 1965, Congress established the Medicaid program as Title XIX of the Social Security Act.[5] Medicaid is a cooperative federal-state program providing federal funds to assist individuals "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396 (1992). States choosing to participate in this optional program are reimbursed for a portion of their costs in providing medical treatment to needy persons. See Atkins v. Rivera, 477 U.S. 154, 156-57, 106 S. Ct. 2456, 2458 (1986); Weber Memorial Care Ctr., Inc. v. Utah Dept. of Health, 751 P.2d 831, 832 (Utah App.), cert. denied, 765 P.2d 1278 (Utah 1988).

Participating states must develop a plan that complies with all federal Medicaid regulations. See 42 U.S.C. § 1396; Atkins, 477 U.S. at 157, 106 S. Ct. at 2458; Weber Memorial, 751 P.2d at 832. Each state must also select a single agency "to administer or to supervise the administration of the plan." 42 U.S.C. § 1396a(a)(5) (1992). In determining eligibility for its program, a state must provide benefits to the "categorically

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4. Allen also argues that his travel trailer, equipped with oxygen, and his truck, both used to transport Allen and his wife to a warmer climate during winter because of his wife's ill health, should be excluded from Medicaid eligibility consideration because they are exempt either as personal effects or medical necessities. See Utah Code Admin. P. R810-304-411(4), (5)(b) to (d) (1991). Furthermore, Allen asserts that, because his wife requires the truck and travel trailer for health reasons, neither vehicle is "available" to him, as contemplated by federal statutory Medicaid requirements. See 42 U.S.C. § 1396a(a)(17)(B) (1992). We find it unnecessary to reach these issues in view of our determination that Allen's savings account alone exceeded the Medicaid eligibility limit.

5. Pub. L. No. 89-97, as amended, 79 Stat. 343 (codified at 42 U.S.C. §§ 1396, et seq. (1992)).

needy"[6] but may provide benefits to the "medically needy"[7] at its discretion.[8]

B. The Concept of "Spend Down" in Federal Medicaid Statutes

When a "medically needy" applicant's income or resources exceed the applicable state's Medicaid eligibility limits, the "spend down" rule may apply. Under this rule, the applicant may be able to "spend down" excess income or assets, by applying them to outstanding medical bills, to become eligible for Medicaid.

In determining whether the federal Medicaid program requires states to adopt the "spend down" rule, courts have focused on the following portion of the Medicaid statutes:

> (a) A State plan for medical assistance must . . .
>
> . . . .
>
> (17) . . . include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are . . . available to the applicant or recipient . . . (C) provide for reasonable evaluation of any such income or resources,

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6. See 42 U.S.C. § 1396a(a)(10)(A)(i).

7. See 42 U.S.C. § 1396a(a)(10)(A)(ii).

8. The United States Supreme Court explained this distinction in Schweiker v. Hogan, 457 U.S. 569, 102 S. Ct. 2597 (1982):

> Congress has differentiated between the categorically needy--a class of aged, blind, disabled, or dependent persons who have very little income--and other persons with similar characteristics who are self-supporting. Members of the former class are automatically entitled to Medicaid; members of the latter class are not eligible unless a State elects to provide benefits to the medically needy and unless their income, after consideration of medical expenses, is below state standards of eligibility.

Id., 457 U.S. at 590, 102 S. Ct. at 2609.

> and (D) . . . provide for flexibility in the application of such standards with respect to income by taking into account . . . the costs . . . incurred for medical care or for any other type of remedial care recognized under State law.

42 U.S.C. § 1396a(a)(17) (1992)(emphasis added). Courts recognize section 17(D) as the "income spend down rule," finding that state plans must permit a Medicaid applicant to "spend down" or deplete excess income to comply with a state's eligibility standards.[9]

The question in the present case, however, is whether the federal Medicaid regulations also require states to allow an applicant to "spend down" excess resources in the same manner. Allen contends that the federal Medicaid program requires states to implement "resource spend down" because it is necessary to fulfill the purpose of the Medicaid program and is reasonable. The DHCF responds that federal Medicaid regulations mandate "income spend down" but merely permit states to incorporate "resource spend down" within their plans at their discretion.

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9. See, e.g., Atkins, 477 U.S. at 158, 106 S. Ct. at 2459 ("the spenddown mechanism of 42 U.S.C. § 1396a(a)(17)" allows the medically needy to spend down "the amount by which their income exceeds" the eligibility level); Foley v. Coler, No. 83-C-4736, 1986 WL 20891 (N.D. Ill. Oct. 1, 1986)("42 U.S.C. § 1396a(a)(17)(D) requires states to use income spend-down"); Harriman v. Commissioner, No. 90-0046-B, 1990 WL 284515 (D. Me. Nov. 9, 1990)(42 U.S.C. § 1396a(a)(17)(D) "specifically requires the state to have an income spend-down rule"); Walter O. Boswell Memorial Hosp., Inc. v. Yavapai County, 148 Ariz. 385, 714 P.2d 878, 881 (Ct. App. 1986)("Federal regulations implementing [42 U.S.C. § 1396a(17)] expressly require deduction of incurred medical bills from income for purposes of determining eligibility."); Ramsey v. Department of Human Servs., 301 Ark. 285, 783 S.W.2d 361, 363 (1990)("Under the 'medically needy' procedure, applicants are permitted to 'spend down' their excess income for medical expenses."); Haley v. Commissioner of Pub. Welfare, 394 Mass. 466, 476 N.E.2d 572, 574 (1985)(42 U.S.C. § 1396a(a)(17) "provide[s] for application of the spend down principle to income eligibility determinations"); Kempson v. North Carolina Dept. of Human Resources, 100 N.C. App. 482, 397 S.E.2d 314, 316 (1990)(The "explicit reference to income [in 42 U.S.C. § 1396a(a)(17)(D)] has been interpreted by the courts to mean that 'income spend-down' is allowed by the statute."), aff'd, 328 N.C. 722, 403 S.E.2d 279 (1991).

Courts considering the issue agree with the DHCF, finding the express statutory mandate is limited to "income spend down."[10] Courts conclude that federal Medicaid regulations permit, but do not require, states to employ "resource spend down."[11] We agree and conclude "resource spend down" is not mandated by federal law.

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10. Legislative history accompanying section 1396a(a)(17) points to only "income spend down" as a mandatory federal requirement. See S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Admin. News 1943.

11. See, e.g., Foley, 1986 WL 20891 ("42 U.S.C. § 1396a(a)(17)(D) requires states to use income spend-down but is silent regarding resource spend-down . . . . Resource spend-down is thus permitted, but not required, by the Medicaid statute and regulations"); Harriman, 1990 WL 284515 ("The federal statute specifically requires the state to have an income spend-down rule. . . . But there is no similar requirement in the federal statute for a resource spend-down rule."); Hession v. Illinois Dept. of Pub. Aid, 129 Ill. 2d 535, 544 N.E.2d 751, 757 (1989)("Simply stated, we perceive nothing in section 1396a(a)(17) which precludes a State that participates in the Medicaid program from using the resource spend down methodology if it chooses to do so."); Hession v. Illinois Dept. of Pub. Aid, 163 Ill. App. 3d 553, 516 N.E.2d 820, 823 (1987)("section 1396a(a)(17) of the Act permits a state plan to utilize resource spend down in determining an applicant's eligibility for medical assistance benefits"), aff'd, 129 Ill. 2d 535, 544 N.E.2d 751 (1989); Harriman v. Commissioner, 595 A.2d 1053, 1055 n.2 (Me. 1991)(court adopts prior holding of district court in this case that federal Medicaid statute "only permits, and does not require, a state to use an asset spend-down"); Bemowski v. Department of Pub. Welfare, 136 Pa. Commw. 103, 582 A.2d 103, 106 (1990)(the provision of medical benefits "to the medically needy by participating States is optional and may be excluded entirely from a State's Medicaid program").

But see Ramsey, 783 S.W.2d at 364 (court finds "no authority in any category for a 'spend-down' of excess resources that is similar or identical to the expressly authorized 'spend-down' of excess income"); Kempson, 397 S.E.2d at 317 (court stops short of holding "resource spend down" discretionary, stating that, although "§ 1396a(a)(17)(D) only mentions income in instructing states to provide flexibility in their program application standards, we note that § 1396(a)(17)(C) instructs that a state's plan must 'provide for reasonable evaluation of any such income or resources'").

C. Utah's Medicaid Program

Since Utah may implement "resource spend down" at its discretion, we must determine whether the Utah Medicaid plan has, in fact, adopted "resource spend down" in determining Medicaid eligibility. Utah courts have never addressed Medicaid "spend down" issues.

Utah chose to participate in the Medicaid program with the adoption of the Medical Assistance Act in 1981.[12] Utah has complied with federal requirements by creating a state plan[13], which has been approved by the Secretary of Health and Human Services, and designating the DHCF as the agency responsible for Medicaid administration.[14] Utah's statutes describe the DHCF's responsibilities, in pertinent part, as follows:

> [T]he division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay.

Utah Code Ann. § 26-18-2.3(1) (1989).

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12. See Utah Code Ann. §§ 26-18-1 to -11 (1989 and Supp. 1991).

13. See Utah Code Admin. P. RR455-1 to -48 (1991). Utah has elected to provide assistance to the "medically needy." See Utah Code Admin. P. R455-1-17 and R455-1-20 (1991). Assets Utah has designated as exempt from Medicaid eligibility determination, including the burial fund discussed earlier, are listed at Utah Code Admin. P. R810-304-411 (1991).

14. "[T]he Division of Health Care Financing . . . shall be responsible for implementing, organizing, and maintaining the Medicaid program . . . in accordance with the provisions of this chapter and applicable federal law." Utah Code Ann. § 26-18-2.1 (1989)(emphasis added); see also Utah Code Ann. § 26-18-3(1) (Supp. 1991)("The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.")(emphasis added).

> (2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

Utah Code Ann. § 26-18-3 (Supp. 1991)(emphasis added).

> The department may develop standards and administer policies relating to eligibility under the Medicaid program.

Utah Code Ann. § 26-18-4(1) (1989).

Allen points to no Medicaid statute, regulation, or rule indicating that the Utah legislature has adopted "resource spend down" in determining Medicaid eligibility. Rather, Allen posits a more delicate argument which goes beyond literal statutory language. Specifically, Allen contends that Utah will not be following the federal requirement to use "reasonable standards" in determining Medicaid eligibility unless it applies "resource spend down."

Furthermore, Allen observes that Utah's Medicaid plan designates certain assets as exempt in determining eligibility for the "medically needy."[15] Allen, thus, argues that Utah has tacitly adopted a policy of allowing "medically needy" Medicaid applicants to maintain a level of income and resources for the necessities of life while still qualifying for Medicaid.

In support of these claims, Allen cites cases from other jurisdictions which, he argues, require "resource spend down" because, like Utah, they exempt certain assets from Medicaid eligibility determination. We read these cases differently. Courts in these jurisdictions have found a state mandate for "resource spend down" based on a specific legislative directive within their Medicaid plans, not just on the practice of allowing exemptions.

In Haley v. Commissioner of Public Welfare, 394 Mass. 466, 476 N.E.2d 572 (1985), the Supreme Judicial Court of Massachusetts closely examined both federal and its own state Medicaid laws to determine if "resource spend down" was mandated or simply permitted. The court, first, determined that, although the federal statutes did not require "resource spend down," it was a reasonable method of calculating resources and "consistent with the goals of Title XIX." Id., 476 N.E.2d at 578. Therefore, the court concluded that it "must determine

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15. See Utah Code Admin. P. R810-304-411 (1991).

independently whether the Legislature intended to require the use of a resource spend down." Id. at 579. The court found a statute "explicitly appl[ying] a resource spend down," id. n.9, as evidence of "the legislature's determination to ensure an individual's retention of a certain level of resources." Id. at 579. The court, thus, held that the Massachusetts Medicaid plan required "resource spend down."

The Supreme Court of Illinois performed an analysis similar to that of the Haley court in Hession v. Illinois Department of Public Aid, 129 Ill. 2d 535, 544 N.E.2d 751 (1989). After concluding that the federal Medicaid statutes permit, but do not require, "resource spend down," the court turned its attention to the Illinois Medicaid plan. The court recognized that the plan included a provision whereby $1,500 in assets is exempt from Medicaid eligibility determination. However, the court, relying upon a specific Illinois statute, also stated: "In establishing an assistance program for these individuals, the legislature has noted that it is of special importance that their incentives for continued independence be maintained and that their limited resources be preserved." Id., 544 N.E.2d at 757 (citing Ill. Rev. Stat. 1987, ch. 23, par. 5-1). Based on this clear manifestation of legislative intent, the court held that the Illinois Medicaid plan required "resource spend down."

Utah does not have such a saving, "resource spend down" provision in its Medicaid plan, nor any statement of policy expressing a desire to preserve the resources of potential beneficiaries.[16] Utah's statutes, particularly those outlining

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16. In fact, one commentator states:

> It is not only conceivable, but a fact that some unprepared applicants' assets are reduced beyond the poverty level to bankruptcy because medical bills in that month exceed those resources which the applicant cannot preserve under the Utah Exemptions Act. It [is] to the applicant's advantage to put forth any plausible argument that a particular value should be counted as income rather than asset, if the reverse would result in excess assets. Excess assets mean a denial of Medicaid eligibility; excess income means that the applicant will be required to shoulder more of [his or] her health care costs for that month.

Ken Bresin, Utah's Medicaid Program: A Senior's Eligibility Guide for Private Practitioners, 14 J. Contemp. L. 1, 9 (1988) (emphasis added)(footnote omitted).

the DHCF's authority[17], seem to evince a legislative concern for economy and efficiency in the Medicaid program, not the preservation of applicants' assets. Jurisdictions requiring "resource spend down," on the contrary, appear concerned about preserving the limited assets of Medicaid applicants.

We, unlike our colleague in dissent, cannot say it was unreasonable for the DHCF to choose not to adopt "resource spend down" in an otherwise completely optional state benefit plan. The expressed legislative concern is for economy and efficiency in implementing a Medicaid program, and we cannot see how this line-drawing offends the legislative delegation of power.

Utah's statutory scheme is more similar to that of Maine, recently reviewed in Harriman v. Commissioner, 595 A.2d 1053 (Me. 1991). In Harriman, the Supreme Judicial Court of Maine recognized that its state plan does not include "resource spend down." "If the assets of applicants exceed the specified dollar limit, they are ineligible for assistance under the medically needy program, regardless of the amount of their medical expenses." Id. at 1056. Noting that "[t]he overall effect was to restrict as much as possible the number of eligible Medicaid recipients," the court stated: "For whatever reason--whether to achieve cost containment or to comply only with the federal mandate or through simple oversight--the legislature stopped short of enacting an asset spend-down." Id. at 1057 (footnote omitted).

We, therefore, conclude there is nothing in the Utah Medicaid plan or its regulations that requires the utilization of "resource spend down."[18] Allen had $3,029.86 in his savings

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17. See, e.g., Utah Code Ann. § 26-18-2.3(1) quoted above.

18. We agree with most courts which have considered the issue and believe the adoption of "resource spend down" is good public policy. See e.g., Foley, 1986 WL 20891 (a state resource spend-down provision furthers the general purpose of the Medicaid program); Harriman, 1990 WL 284515 ("Clearly, if the goal of Medicaid is to assist individuals who are medically needy--defined as having insufficient income or resources to meet the cost of necessary medical services--the sensible solution is the spend-down rule."); Hession, 516 N.E.2d at 823 (a state's adoption of resource spend down "would be in conformity with the purpose and spirit of the Act"); Kempson, 397 S.E.2d at 318 ("Our review of the case law reveals a pattern where Medicaid applicants are blindsided by this eligibility requirement simply because it is so illogical. Applicants who otherwise qualify are

(continued...)

account at the time he applied for Medicaid. The DHCF, thus, correctly determined he was ineligible for Medicaid benefits as Utah has not adopted a "resource spend down" system.

Judith M. Billings,
Associate Presiding Judge

I CONCUR:

Leonard H. Russon, Judge

BENCH, Presiding Judge (concurring in part and dissenting in part):

I concur with part I of the main opinion and dissent from part II.

Whether a "medically needy" applicant may have been eligible for Medicaid by spending down his or her assets is a policy decision delegated in Utah to DHCF by Utah Code Ann. § 26-18-4(1) (1989). We review for reasonableness an agency's policy based on a legislative grant of discretion to interpret a statute. See Morton Int'l, Inc. v. Auditing Div. State Tax Comm'n, 814 P.2d 581 (Utah 1991).[1]

18.(...continued)
denied coverage because they have several hundred dollars above the reserve asset limit while at the same time they are liable for tens of thousands of dollars worth of medical bills.").

Nevertheless, a determination of the eligibility criteria for Medicaid benefits is not one for the courts to make.

1. I disagree with the majority's interpretation of Utah Code Ann. § 26-18-2.3(1) (1989) as an expression of intent to limit coverage. The Legislature's concern for economy and efficiency in the administration of the program simply does not have any logical relationship to the intended coverage of the program.

I do not believe the policy adopted by DHCF is reasonable since eligibility is determined by when the medically needy applicant applies for benefits. Under DHCF's policy, the applicant who is savvy enough to spend down his or her assets before applying for medicaid would be eligible, while the applicant who applies for benefits before spending down is not eligible. Because that agency policy is not reasonable, I would allow Allen to spend down his assets before his eligibility is determined.

I would therefore reverse and remand the case for further proceedings.

Russell W. Bench,
Presiding Judge

Rule 29. Oral argument.

(a) *In general. Oral argument will be allow*
all cases unless the court concludes:

(1) The appeal is frivolous; or

(2) The dispositive issue or set of issue
been recently authoritatively decided; or

(3) The facts and legal arguments are
quately presented in the briefs and recor
the decisional process would not be signific
aided by oral argument.

(b) **Priority of argument. Cases shall b**
uled for oral argument in accordance with th
ing list of priorities:

(1) Appeals from convictions in whi
death penalty has been imposed;

(2) Appeals from convictions in all other
nal matters;

(3) Appeals from habeas corpus petitions
other post-conviction proceedings; and

(4) Appeals from orders concerning cust
tody or termination of parental rights

(5) Matters relating to the discipline of attorneys;

(6) Matters relating to applicants who have failed to pass the bar examination,

(7) Petitions for review of Industrial Commission orders;

(8) Appeals from the orders of the Juvenile Court;

(9) Appeals from actions involving public elections;

(10) Petitions for review of Public Service Commission orders,

(11) Appeals from interlocutory orders,

(12) Questions certified to the Supreme Court by a court of the United States,

(13) Original writ proceedings,

(14) Petitions for certiorari that have been granted,

(15) Petitions to review administrative agency orders not included within other categories, and

(16) Any matter not included within the above categories

(c) **Notice by clerk and request by a party for argument; postponement.** Not later than 30 days prior to the term of court in which a case is to be submitted, the clerk shall give notice to all parties that oral argument is to be permitted, the time and place of oral argument, and the time to be allowed each side Oral argument shall proceed as scheduled unless all parties waive the same in writing filed with the clerk not later than 15 days from the date of the clerk's notice A request for postponement of the argument or for allowance of additional time must be made by motion filed reasonably in advance of the date fixed for hearing

(d) **Order and content of argument.** The appellant is entitled to open and conclude the argument The opening argument shall include a fair statement of the case Counsel will not be permitted to read at length from briefs, records or authorities

(e) **Cross and separate appeals.** A cross or separate appeal shall be argued with the initial appeal at a single argument, unless the court otherwise directs If a case involves a cross-appeal, the plaintiff in the action below shall be deemed the appellant for the purpose of this rule unless the parties otherwise agree or the court otherwise directs If separate appellants support the same argument, care shall be taken to avoid duplication of argument

(f) **Non-appearance of parties.** If the appellee fails to appear to present argument, the court will hear argument on behalf of the appellant, if present If the appellant fails to appear, the court may hear argument on behalf of the appellee, if present If neither party appears, the case may be decided on the briefs, or the court may direct that the case be rescheduled for argument

(g) **Submission on briefs.** By agreement of the parties, a case may be submitted for decision on the briefs, but the court may direct that the case be argued.

(h) **Use of physical exhibits at argument; removal.** If physical exhibits other than documents are to be used at the argument, counsel shall arrange to have them placed in the courtroom before the court convenes on the date of the argument After the argument, counsel shall remove the exhibits from the courtroom unless the court otherwise directs If exhibits are not reclaimed by counsel within a reasonable time after notice is given by the clerk, they shall be destroyed or otherwise disposed of as the clerk shall think best

Mar. 15, 1979; 48 FR 57127, Dec. 28, 1983; 51 FR 34464, Sept. 29, 1986; 55 FR 28378, July 11, 1990]

§ 416.1212 Exclusion of the home.

(a) *Defined.* A home is any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

(b) *Home not counted.* We do not count a home regardless of its value. However, see §§ 416.1220 through 416.1224 when there is an income-producing property located on the home property that does not qualify under the home exclusion.

(c) *If an individual changes principal place of residence.* If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. If an individual leaves his or her home to live in an institution, we still consider the home to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

(d) *Proceeds from the sale of an excluded home.* The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within 3 months of the date of receipt of the proceeds.

[50 FR 42686, Oct. 22, 1985, as amended at 51 FR 7437, Mar. 4, 1986]

§ 416.1216 Exclusion of household goods and personal effects.

(a) *Household goods and personal effects; defined.* Household goods are defined as including household furniture, furnishings and equipment which are commonly found in or about a house and are used in connection with the operation, maintenance, and occupancy of the home. Household goods would also include the furniture, furnishings and equipment which are used in the functions and activities of home and family life as well as those items which are for comfort and accommodation. Personal effects are defined as including clothing, jewelry, items of personal care, individual education and

(b) *Limitation on household goods and personal effects.* In determining the resources of an individual (and spouse, if any), household goods and personal effects are excluded if their total equity value is $2,000 or less. If the total equity value of household goods and personal effects is in excess of $2,000, the excess is counted against the resource limitation.

(c) *Additional exclusions of household goods and personal effects.* In determining the resources of an individual (and spouse, if any) and in determining the value of the household goods and personal effects of such individual (and spouse), there shall be excluded a wedding ring and an engagement ring and household goods and personal effects such as prosthetic devices, dialysis machines, hospital beds, wheel chairs and similar equipment required because of a person's physical condition. The exclusion of items required because of a person's physical condition is not applicable to items which are used extensively or primarily by members of the household in addition to the person whose physical condition requires the item.

[40 FR 48915, Oct. 20,1975, as amended at 44 FR 43266, July 24, 1979]

§ 416.1218 Exclusion of the automobile.

(a) *Automobile; defined.* As used in this section, the term *automobile* includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

(b) *Limitation on automobiles.* In determining the resources of an individual (and spouse, if any), automobiles are excluded or counted as follows:

(1) *Total exclusion.* One automobile is totally excluded regardless of its value if, for the individual or a member of the individual's household—

(i) It is necessary for employment;

(ii) It is necessary for the medical treatment of a specific or regular medical problem;

(iii) It is modified for operation by or transportation of a handicapped person; or

(iv) It (or other type of vehicle) is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

(2) *Exclusion to $4,500 of the market value.* If no automobile is excluded under paragraph (b)(1) of this section, one automobile is excluded from counting as a resource to the extent its current market value does not exceed $4,500. If the market value of the automobile exceeds $4,500, the excess is counted against the resource limit.

(3) *Other automobiles.* Any other automobiles are treated as nonliquid resources and counted against the resource limit to the extent of the individual's equity (see § 416.1201(c)).

(c) *Current market value.* The *current market value* of an automobile is the average price an automobile of that particular year, make, model, and condition will sell for on the open market (to a private individual) in the particular geographic area involved.

[40 FR 48915, Oct. 20, 1975, as amended at 44 FR 43266, July 24, 1979; 50 FR 42687, Oct. 22, 1985]

§ 416.1220 Property essential to self-support; general.

When counting the value of resources an individual (and spouse, if any) has, the value of property essential to self-support is not counted, within certain limits. There are different rules for considering this property depending on whether it is income-producing or not. Property essential to self-support can include real and personal property (for example, land, buildings, equipment and supplies, motor vehicles, and tools, etc.) used in a trade or business (as defined in § 404.1066 of part 404), nonbusiness income-producing property (houses or apartments for rent, land other than home property, etc.) and property used to produce goods or services essential to an individual's daily activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. If the individual's principal place of residence qualifies under the home exclusion, it is not considered in evaluating property essential to self-support.

[50 FR 42687, Oct. 22, 1985]

§ 416.1222 How income-producing property essential to self-support is counted.

(a) *General.* When deciding the value of property used in a trade or business or nonbusiness income-producing activity, only the individual's equity in the property is counted. We will exclude as essential to self-support up to $6,000 of an individual's equity in income-producing property if it produces a net annual income to the individual of at least 6 percent of the excluded equity. If the individual's equity is greater than $6,000, we count only the amount that exceeds $6,000 toward the allowable resource limit specified in § 416.1205 if the net annual income requirement of 6 percent is met on the excluded equity. If the activity produces less than a 6-percent return due to circumstances beyond the inividual's control (for example, crop failure, illness, etc.), and there is a reasonable expectation that the individual's activity will again produce a 6-percent return, the property is also excluded. If the individual owns more than one piece of property and each produces income, each is looked at to see if the 6-percent rule is met and then the amounts of the individual's equity in all of those properties producing 6 percent are totaled to see if the total equity is $6,000 or less. The equity in those properties that do not meet the 6-percent rule is counted towards the allowable resource limit specified in § 416.1205. If the individual's total equity in the properties producing 6-percent income is over the $6,000 equity limit, the amount of equity exceeding $6,000 is counted as a resource towards the allowable resource limit.

them under the State's AFDC plan); or

(2) Would be eligible for AFDC if the State's AFDC plan did not contain eligibility requirements more restrictive than, or in addition to, those required under Title IV-A.

(b) The agency may cover any AFDC optional group without covering all such groups.

[46 FR 47985, Sept. 30, 1981]

OPTIONS FOR COVERAGE OF THE AGED, BLIND, AND DISABLED

§ 435.230 Individuals receiving only optional State supplements.

(a) The agency may provide Medicaid, in one or more of the following classifications, to individuals who receive only an optional State supplement that meets the conditions specified in paragraph (b) of this section and who would be eligible for SSI except for the level of their income:

(1) All aged individuals.

(2) All blind individuals.

(3) All disabled individuals.

(4) Only aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Only blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Only disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a federally administered optional State supplement that meets the conditions specified in this section.

(8) Individuals in additional classifications specified by the Secretary for federally administered supplementary payments under 20 CFR 416.2020(d).

(b) Payments under the optional supplement program must be—

(1) Based on need and paid in cash on a regular basis;

(2) Equal to the difference between the individual's countable income and the income standard used to determine eligibility for supplement. Countable income is income remaining after deductions required under SSI or, at State option, more liberal deductions are made (see § 435.1006 for limitations on FFP in Medicaid expenditures for individuals receiving optional State supplements); and

(3) Available to all individuals in the State; however, the plan may provide for variations in the income standard by political subdivision according to cost-of-living differences.

§ 435.231 Individuals in institutions who are eligible under a special income level.

(a) If the agency provides Medicaid under § 435.211 to individuals in institutions who would be eligible for AFDC, SSI, or State supplements except for their institutional status, it may also cover aged, blind, and disabled individuals in institutions who—

(1) Because of their income, would not be eligible for SSI or State supplements if they were not institutionalized; but

(2) Have income below a level specified in the plan under § 435.722. (See § 435.1005 for limitations on FFP in Medicaid expenditures for individuals specified in this section.)

(b) The agency may cover individuals under this section whether or not the State pays optional supplements.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24884, Apr. 11, 1980]

Subpart D—Optional Coverage of the Medically Needy

§ 435.300 Scope.

This subpart specifies the option for coverage of medically needy individuals.

§ 435.301 General rules.

(a) A medicaid agency may provide Medicaid to individuals specified in this subpart who—

(1) Either—

(i) Have income that meets the applicable standards in §§ 435.812 through 435.814; or

(ii) If their income is more than allowed under those standards, have incurred medical expenses at least equal to the difference between their income and the applicable income standard; and

(2) Have resources that meet the applicable standards in §§ 435.840 through 435.843.

(d) *Optional deductions.* In determining the amount of the individual's income to be used to reduce the agency's payment to the institution, the agency may deduct the following amounts from the individual's total income as determined under paragraph (e) of this section:

(1) Necessary medical or remedial services included in the State's Medicaid plan for the medically needy, which exceed limitations on amount, duration or scope imposed by the agency, subject to reasonable limits the agency may establish on amounts of these expenses;

(2) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses; and

(3) For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if—

(i) The amount is deducted for not more than a 6-month period; and

(ii) A physician has certified that either of the individuals is likely to return to the home within that period.

(e) *Determination of income*—(1) *Option.* In determining the amount of an individual's income to be used to reduce the agency's payment to the institution, the agency may use total income received or it may project total monthly income for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the projection on income received in the preceding period, not to exceed 6 months, and on income expected to be received.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (e)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with income received.

(f) *Determination of medical expenses*—(1) *Option.* In determining the amount of medical expenses to be deducted from an individual's income, the agency may deduct incurred medical expenses, or it may project medical expenses for a prospective period not to exceed 6 months.

(2) *Basis for projection.* The agency must base the estimate on medical expenses incurred in the preceding period, not to exceed 6 months, and medical expenses expected to be incurred.

(3) *Adjustments.* At the end of the prospective period specified in paragraph (f)(1) of this section, or when any significant change occurs, the agency must reconcile estimates with incurred medical expenses.

[45 FR 24886, Apr. 11, 1980, as amended at 46 FR 47988, Sept. 30, 1981; 48 FR 5735, Feb. 8, 1983; 53 FR 3596, Feb. 8, 1988; 53 FR 5344, Feb. 23, 1988]

MEDICALLY NEEDY RESOURCE STANDARDS

§ 435.840 Medically needy resource standards: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a resource standard under this subpart that is—

(a) Based on family size;

(b) Uniform for all individuals in a group; and

(c) Reasonable. (See § 435.841)

[46 FR 47988, Sept. 30, 1981; 46 FR 54734, Nov. 11, 1981]

§ 435.841 Medically needy resource standards: Reasonableness.

(a) The agency must use a medically needy resource standard that is reasonable, according to the provisions of this section.

(b) The following medically needy resource standards are presumed to be reasonable:

(1) The agency provides one medically needy resource standard for all covered medically needy groups. Except as provided in paragraph (c) of this section, the standard must at least equal the highest resource standard used to determine eligibility in the cash assistance programs related to the covered medically needy groups.

(2) The agency provides a different medically needy resource standard for each covered medically needy group. Except as provided in paragraph (c) of this section, the standard for each covered group must at least equal the highest resource standard used to determine eligibility in the cash assist-

ance program related to that covered medically needy group.

(c) In the case of an agency that provides Medicaid for the aged, blind, or disabled individuals only if they meet more restrictive requirements than used under SSI, the following provisions apply:

(1) The agency may use a resource standard for those individuals that is lower than the standard specified in paragraph (b) of this section.

(2) The lower standard must at least equal the medically needy resource standard for those aged, blind, or disabled individuals under the State's plan on January 1, 1972.

(d) If the agency uses a medically needy resource standard not specified in paragraphs (b) and (c) of this section—

(1) That standard is not presumed to be reasonable; and

(2) HCFA must approve the standard.

[46 FR 47988, Sept. 30, 1981; 46 FR 54743, Nov. 11, 1981]

§ 435.843 Medically needy resource standards: State plan requirements.

(a) The State plan must specify the resource standard for each covered medically needy group.

(b) If the agency uses a resource standard that is not presumed to be reasonable under § 435.841, the State plan must describe that standard.

[46 FR 47989, Sept. 30, 1981]

Determining Eligibility on the Basis of Resources

§ 435.845 Medically needy resource eligibility.

To determine eligibility on the basis of resources for medically needy individuals, the agency must—

(a) Consider only the individual's resources and those that are considered available to him under the financial responsibility requirements for relatives in § 435.821, § 435.822, or § 435.823;

(b) Consider only resources available during the period for which income is computed under § 435.831(a);

(c) For individuals under age 21 and caretaker relatives, deduct the value of resources that would be deducted in determining eligibility under the State's AFDC plan;

(d) For aged, blind, or disabled individuals in States covering all SSI recipients, deduct the value of resources that would be deducted in determining eligibility under SSI;

(e)(1) For aged, blind, or disabled individuals in States using requirements more restrictive than SSI, deduct the value of resources in an amount no more restrictive than those deducted under the Medicaid plan on January 1, 1972 and no more liberal than those deducted in determining eligibility under SSI.

(2) However, the amounts specified in paragraph (e)(1) of this section must be the same as those that would be deducted in determining, under § 435.121, the eligibility of the categorically needy; and

(f) Apply the resource standards established under § 435.843.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24886, Apr. 11, 1980; 46 FR 47989, Sept. 30, 1981]

Treatment of Income and Resources

§ 435.850 Treatment of income and resources: General requirements.

To determine eligibility of medically needy individuals, a Medicaid agency must use a methodology for the treatment of income and resources that is—

(a) Uniform for all individuals in a covered group; and

(b) Reasonable (see § 435.851).

[46 FR 47989, Sept. 30, 1981]

§ 435.851 Treatment of income and resources: Reasonableness.

(a) The agency must use a methodology for the treatment of income and resources, to determine eligibility of the medically needy, that is reasonable.

(b) The methodology used to determine eligibility of individuals in the cash assistance program related to the covered medically needy group is presumed to be reasonable.

(c) If the agency provides Medicaid for the aged, blind, or disabled individuals who meet more restrictive requirements than used under SSI, the methodology for the treatment of

Categorically needy means aged, blind, or disable individuals or families and children

(a) Who are otherwise eligible for Medicaid and who meet the financial eligibility requirements for OAA, AFDC, AB, APTD, or AABD; or,

(b) Whose categorical eligibility is protected by statute (e.g., persons who received increased OASDI payments. See § 436.112).

Families and children refers to eligible members of families with children who are financially eligible under AFDC or medically needy rules and who are deprived of parental support or care as defined under the AFDC program (see 45 CFR 233.90; 233.100). In addition, this group includes individuals under age 21 who are not deprived of parental support or care but who are financially eligible under AFDC or medically needy rules (see optional coverage group, § 436.222);

Medically needy means aged, blind, disabled individuals or families and children who are otherwise eligible for Medicaid, who are not categorically needy and whose income and resources are within limits set under the Medicaid State plan.

OAA means old age assistance under title I of the Act;

OASDI means old age, survivors, and disability insurance under Title II of the Act.

[43 FR 45218, Sept. 29, 1978, as amended at 45 FR 24887, Apr. 11, 1980; 46 FR 47989, Sept. 30, 1981]

§ 436.10 State plan requirements.

A State plan must—

(a) Provide that the requirements of this part are met; and

(b) Specify the groups to whom Medicaid is provided, as specified in subparts B, C, and D of this part, and the conditions of eligibility for individuals in those groups.

Subpart B—Mandatory Coverage of the Categorically Needy

§ 436.100 Scope.

This subpart prescribes requirements for coverage of categorically needy individuals.

§ 436.110 Individuals receiving cash assistance.

(a) A Medicaid agency must provide Medicaid to individuals receiving cash assistance under OAA, AFDC, AB, APTD, or AABD.

(b) For purposes of this section, an individual is receiving cash assistance if his needs are considered in determining the amount of the payment. This includes an individual whose presence in the home is considered essential to the well-being of a recipient under the State's plan for OAA, AFDC, AB, APTD, or AABD if that plan were as broad as allowed under the Act for FFP.

§ 436.111 Individuals who are not eligible for cash assistance because of a requirement not applicable under Medicaid.

The agency must provide Medicaid to individuals who would be eligible for OAA, AFDC, AB, APTD, or AABD except for an eligibility requirement used in those programs that is specifically prohibited under title XIX.

[47 FR 43648, Oct. 1, 1982]

EDITORIAL NOTE: Section 436.111 was revised at 47 FR 43648, Oct. 1, 1982. The reporting and/or recordkeeping requirements contained in this section are not effective until OMB approval has been obtained.

§ 436.112 Individuals who would be eligible for cash assistance except for increased OASDI under Pub. L. 92-336 (July 1, 1972).

The agency must provide Medicaid to individuals who meet the following conditions:

(a) In August 1972, the individual was entitled to OASDI and—

(1) He was receiving cash assistance; or

(2) He would have been eligible for cash assistance if he had applied, and the Medicaid plan covered this optional group; or

(3) He would have been eligible for cash assistance if he were not in a medical institution or intermediate care facility, and the Medicaid plan covered this optional group.

(b) The individual would currently be eligible for cash assistance except that the increase in OASDI under

R455-9. Nursing Facility Preadmission/Continued Stay Review and Level of Care Criteria.
R455-10. Pharmacy Policy.
R455-11. Podiatry Services.
R455-11x. Dental Services.
R455-12. Medical Supplies Durable Medical Equipment — Prosthetics.
R455-13. Psychology Services.
R455-13x. Section V of all Medicaid Provider Manuals: "Provider Compliance".
R455-14. Home Health Services.
R455-14A. Hospice Care.
R455-15. Patients Personal Needs Fund.
R455-16. Preadmission and Continued Stay Review Policy and Procedures Manual.
R455-17. Policy on Use of Oxygen Concentrators.
R455-18. Medicaid Payment Reductions.
R455-19. Percent of Mean Upper Limit for Medicaid Reimbursement.
R455-19A. Coverage for Dialysis Services by a Free-Standing State Licensed Dialysis Facility.
R455-20. Dental Service.
R455-20B. Dental, Oral and Maxillofacial Surgeons.
R455-20x. Rule Exempting from 10% Rule.
R455-21. Physical Therapy.
R455-22. Administrative Sanction Procedures and Regulations.
R455-23. Provider Compliance with Medicaid Policy and Procedures.
R455-24. Policy concerning the timeframe in which Medicaid claims must be submitted for payment.
R455-25. Mental Health Clinic Services.
R455-25x. Policy concerning the timeframe in which Medicaid claims must be submitted for payment.
R455-26. Implementation and Maintenance of the Health Care Financing Administration Common Procedure Coding System (HCPCS).
R455-27. Medicare Nursing Home Certification.
R455-28. Record Keeping and Disclosure for Medicaid Providers.
R455-29. Recipient Review/Education and Restriction Policy.
R455-30. Bureau of Facility Management Policy and Procedures Manual Part B, Hospital Preadmission and Continued Stay Review.
R455-31. Inpatient Psychiatric Services for Individuals Under Age 21 in Psychiatric Facilities or Programs.
R455-31x. Hospital Utilization Review.
R455-32. Hospital Record-keeping Policy.
R455-33. Targeted Case Management Services.
R455-33A. Targeted Case Management For The Chronically Mentally Ill.
R455-34. Record-Keeping and Physician Order Requirements for Ancillary Services.
R455-35. Naturopathic Services Not a Medicaid Benefit.
R455-36. Bureau of Facility Management Policy and Procedures Manual.
R455-38. Personal Care Service.
R455-39. Home and Community-Based Services Waiver.
R455-39x. Day Treatment Rate.
R455-40. Nursing Service.
R455-41. Increase in Fees for dental, kidney dialysis, medical transportation, nurse midwife, physical therapy, rural health clinics, speech and hearing, vision, home health agency, ambulatory surgical and outpatient hospital.
R455-42. Limitations on Scope of Service for Inpatient Hospitals and Outpatient Hospitals and Limitations on Scope of Service for Psysician Services.
R455-45. Personal Supervision.
R455-48. Out-of-State Services.

R455-1. State Plan Under Title XIX of the Social Security Act Medical Assistance Program of Utah.

R455-1-1
R455-1-2. Section 1: Single State Agency Organization.
R455-1-3 to R455-1-9.
R455-1-10. Section 2: Coverage and Eligibility.
R455-1-11 to R455-1-31.
R455-1-32. Section 4: General Program Administration.
R455-1-33 to R455-1-79.
R455-1-80. Section 5: Personnel Administration.
R455-1-82
R455-1-83. Section 6: Financial Administration.
R455-1-84
R455-1-85
R455-1-86. Section 7: General Provisions.
R455-1-87
R455-1-88

R455-1-1

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the UTAH STATE DEPARTMENT OF HEALTH (single State agency) submits the following State plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

R455-1-2. Section 1: Single State Agency Organization.

1.1 Designation and Authority

(a) The UTAH STATE DEPARTMENT OF HEALTH is the single State Agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named in this paragraph).

Attachment 1.1A is a certification signed by the State Attorney General identifying the single State agency and citing the legal authority under which it administers or supervises administration of the program.

R455-1-3

1.1(b) The State agency that administered or supervised the administration of the plan approved under title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that part of this plan which relates to blind individuals.

X Not applicable. The entire plan under title XIX is administered or supervised by the State agency named in paragraph 1.1(a).

R455-1-4

1.1(c) Waivers of the single State agency requirement which are currently operative have been granted under authority of the Intergovernmental Cooperation Act of 1968.

X Not applicable. No waivers have ever been granted.

R455-1-5

1.1(d)

X Determinations of eligibility for Medicaid under this plan are made by the agency(ies) specified in Attachment 2.2A. There is a written agreement between the agency named in paragraph 1.1(a) and other agency(ies) making such determinations for specific groups covered under this plan. The agreement defines the relationships and respective responsibilities of the agencies.

R455-1-6

1.1(e) All other provisions of this plan are administered by the Medicaid agency except for those functions for which final authority has been granted to a Professional Standards Review Organization under title XI of the Act.

(f) All other requirements of 42 CFR 431.10 are met.

R455-1-7

1.2 Organization for Administration

(a) Attachment 1.2A contains a description of the organization and functions of the Medicaid agency and organization chart of the agency.

(b) Within the State agency, the DIVISION OF HEALTH CARE FINANCING AND STANDARDS has been designated as the medical assistance unit. Attachment 1.2B contains a description of the organization and functions of the medical assistance unit and an organization chart of the unit.

(c) Attachment 1.2C contains a description of the kinds and numbers of professional medical personnel and supporting staff used in the administration of the plan and their responsibilities

(d) Eligibility determinations are made by State or local staff of an agency other than the agency named in paragraph 1.1(a). Attachment 1.2D contains a description of the staff designated to make such determination and the functions they will perform.

R455-1-8

1.3 Statewide Operation

The plan is in operation on a Statewide basis in accordance with all requirements of 42 CFR 431.50.

X The plan is state administered.

R455-1-9

1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

R455-1-10. Section 2: Coverage and Eligibility.

2.1 Application, Determination of Eligibility and Furnishing Medicaid

(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility and furnishing Medicaid.

R455-1-11

2.1(b) Individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6A.

2.1(c) The Medicaid agency elects to enter into a risk contract with an HMO that is

X Not Federally qualified, but meets the requirements of 42 CFR 434.20(c) and is defined in Attachment 2.1A.

R455-1-12

2.2 Coverage and Conditions of Eligibility

Medicaid is available to groups specified in Attachment 2.2A.

X Both categorically needy and medically needy

The conditions of eligibility that must be met are specified in Attachment 2.6A.

All applicable requirements of 42 CFR Part 435 are met.

R455-1-13

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403.

R455-1-14

2.4 Blindness

(a) The definition of blindness in terms of ophthalmic measurement used in this plan is specified in Attachment 2.6A.

(b) All other requirements of 42 CFR 435.530 and 42 CFR 435.531 are met.

R455-1-15

2.5 Disability

(a) The definition of disability that is used in this plan is specified in Attachment 2.6A.

(b) All other requirements of 42 CFR 435.540 and 435.541 are met.

R455-1-16

2.6 Financial Eligibility

(a) Categorically needy

(1) With respect to AFDC-related families and individuals under age 21 (not otherwise eligible under this plan), the financial eligibility conditions of the State's approved AFDC plan apply.

(2) With respect to aged, blind and disabled individuals, the financial eligibility conditions described in Attachment 2.6A apply.

(3) All requirements of 42 CFR Part 435; Subparts G and H are met with respect to the families and individuals to whom the requirements apply.

R455-1-17

2.6(b) Medically needy

All requirements of 42 CFR Part 435, Subparts G and I are met with respect to the families and individuals to whom the requirements apply. The level of income and resources, expressed in total dollar amounts, that are used as a basis for establishing eligibility under the plan are as described in Attachment 2.6A.

R455-1-18

2.7 Medicaid Furnished out of State

Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another state, to the same extent that Medicaid is furnished to residents in the State.

R455-1-19

3.1 Amount, Duration and Scope of Services

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B.

(1)(i) Each item of service listed in section 1905(a)(1) through (5) of the Act, as defined in 42 CFR Part 440, Subpart A is provided for the categorically needy.

(ii) Nurse-midwife services listed in section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided for the categorically needy to the extent

5. Subtract medical insurance premiums and payments for medical services, see section 309.32.

6. If the client is a resident of a nursing home, the client must pay the rest of the income to the nursing home. If the client is a resident of another kind of medical institution, the client must spend down to the district office.

R810-303-375. Changes In Circumstances — Residents of Medical Institutions.

See Sec. 209.2 for a definition of a medical institution. See Sec. 365.1 for a definition of a resident of a medical institution.

375.1 Client Responsibility

The client is responsible to report within 10 days any change in income or circumstances which may affect eligibility.

375.2 Date of Income Change

Consider the date of receipt of income as the date of change.

R810-303-377. Residents of Medical Institutions and Veteran's Administration (VA) Benefits.

A VA benefit recipient may be eligible for increased benefits when they enter a medical institution. These increased benefits are called Aid and Attendance. Also, potential VA recipients may become eligible for VA benefits when they enter a medical institution. Potential recipients include a veteran, or the spouse, parent, or child of a veteran.

When you identify a recipient or potential recipient who has entered a medical institution, take one of these actions:

1. Notify ORS.
2. If the client or his family wishes to apply directly to the VA, they may do so. Notify ORS.
3. If the OCO worker wishes to apply directly with the VA, you may do so. Notify ORS.

To notify ORS, use VA Form 21-8416a (Request for Information Concerning Unreimbursed Family Medical Expenses). This form is the minimum that you must send to ORS. If you have more information or a copy of the complete application, send it too. Send the form as soon as possible after application. The VA will pay only from the date this form is received by them.

If the client is in a nursing home, tell the nursing home operator to immediately report any increased benefits. Control for the increased benefits on Form 62 or Form 69.

If you have any questions about application for increased veteran's benefits, you may call the ORS Veteran's Benefits Coordinator at 538-4534.

377.1 Treatment of Lump Sum VA Benefits

Break any lump sum payment into Aid and Attendance and regular pension.

1. Tell ORS of the Aid and Attendance amount. ORS will collect any Aid and Attendance for the time period that the client recieved Medicaid.
2. Consider the remainder of a VA lump sum payment as income in the month received. If the client is a resident of a nursing home and it is too late to be correctly reflected on the APA file, use the Form 417A to notify the nursing home and HCF.

R810-304. Medicaid: Asset Standards.

R810-304-400. Asset Standards.
R810-304-403. Asset Limits.
R810-304-405. Real Property.
R810-304-407. Personal Property.
R810-304-409. Availability of Assets.
R810-304-411. Exempt Assets.
R810-304-419. When to Deem Assets.
R810-304-421. Lump Sum Payments — All Cases.
R810-304-425. Income Producing Property.
R810-304-431. Transfer of Excess Assets.
R810-304-441. Third Party Liability (TPL) — All Cases.
R810-304-443. Eligible Aliens and Counting The Assets of Sponsors — All Cases.
R810-304-461. Whose Assets to Count — Clients Who Are Not Residents of Medical Institutions.
R810-304-465. Whose Assets to Count — Clients Who Are Residents of Medical Institutions.

R810-304-400. Asset Standards.

1. This section describes asset* standards for all Medicaid clients.
2. An Asset is available when the client owns it, or has the legal right to sell it or dispose of it for his own benefit. (See Sec. 409.)
3. The assets of a ward controlled by a legal guardian are available to the ward. This is true even if the ward is not living with the guardian. If the asset is a trust, follow the rules on trusts. (See Sec. 409.6.)
4. Do not count money as an asset in the same month it is counted as income.

R810-304-403. Asset Limits.

Base asset levels on the same number of persons included in the Basic Maintenance Standard (BMS):

Number In BMS	Asset Level
1 person BMS	$2,000
2 person BMS	$3,000
Each additional person in the BMS	add $25

Use section 329 to set the number of persons in the BMS.

Close the case or deny the application when the countable value of all assets is more than the asset limits.

403.1 The Value of Assets

Judge assets by their equity value. An exception is made for vehicles in A, B and D cases. (See Sec. 411-5.)

1. Equity value is the current market value less any debts owing on the asset.
2. Current market value is the item's selling price on the open market as set by current standards of appraisal.

Assets: Any real or personal property that has money value. (See Sec. 405 and 407)

403.11 F and C Cases

For both applications and open cases, if asset levels are met at any time in a month, they are met for the entire month.

403.12 A,B, and D Cases

For both applicants and open cases, use assets held on the first moment of a calendar month to compute eligibility for that month. The case is ineligible for the entire month if countable assets exceed limits on the first moment of the month.

1. However, when the asset level is exceeded and a checking account is part of it, look at checks written prior to the first moment of the month which had not cleared as of the first moment.
2. Do not count such checks in the asset computation.

Subtract these checks from the checking balance.

403.2 SSI Recipient

An SSI recipient must meet Medicaid asset limits. When these limits are exceeded, close the case or deny the application.

403.3 Deeming of Parental Assets to D and B Children

When a D or B unemancipated child is a Medicaid recipient and lives with his parents, count his parents' assets. It does not matter whether either parent is eligible. In this situation, follow the rules below:

1. Apply all asset exclusions of the D or B program to the parent's assets.

2. From the value of the parent's countable assets, deduct the one person $1,900 or two person $2,850 asset limit depending on whether there are 1 or 2 parents in the home. Do not allow the $25.00 exemption for each additional household member.

3. When more than one child is D or B, divide the parents' countable assets equally between each eligible child.

4. Allow each eligible B or D child the $1,900 limit in total countable assets.

Example:

The Blakes have five children living at home. Tom (age 17) and Tim (age 16) are SSI recipients. Neither Tom nor Tim have any assets of his own. Mr. and Mrs. Blake have a $5,000.00 savings account. Of this $2,850.00 is exempt as a parental asset exclusion. This leaves a countable asset of $2,150.00 ($5,000.00 - $2,850.00 = $2,150.00). Of this $1,075.00 is deemed to each eligible D or B child ($2,150.00 divided by 2 equals $1,075.00). In this example neither child's assets exceed $1,900.00. Both are eligibile based on their assets.

R810-304-405. Real Property.

Real property includes items which may be fixed or permanent, such as land, houses, buildings, and trailer homes.

R810-304-407. Personal Property.

Personal property is an item other than real property. Some examples are:

1. Liquid assets such as savings and checking accounts, stocks, water stock, bonds, mutual fund shares, promissory notes, mortgages, insurance policies, trust funds, and agreements in escrow.
2. Motor vehicles, including automobiles, trucks, motorbikes, snowmobiles, etc.
3. Boats, campers and trailers.
4. Implements, instruments, and tools.
5. Livestock.
6. Merchandise and inventory.
7. Time shares and time share agreements.

Liquid Assets: Assets in cash or payable in cash on demand.

R810-304-409. Availability of Assets.

409.1 Joint Accounts

1. When an account is jointly held by a client and someone who is not eligible, count all the funds as an asset for the client if he can legally withdraw funds from the account. If more than one of the account holders is eligible, divide the funds equally among

If the client claims that the asset does not belong to him allow him to refute it. He can refute it by providing things:

His statement about the ownership of the funds. The statement should include the reason the joint account was set up and who made the deposits to and withdrawals from the account, and

Supporting statements from the other account

If the asset belongs to someone else, the money must be removed or access must be restricted. If this is not done, count all the funds as an asset for the entire time access was not restricted. If access is restricted, do not count the asset back through the entire period the client is able to refute his ownership.

Example: In October you discover Mr. Jones had a savings account in his name and that of his father. Mr. Jones has been a joint owner of this account since January when first started receiving assistance. He proves that all deposits and withdrawals have been made by his father and are his father's money. Mr. Jones has his name removed from the account in October. Exempt the asset back to January.

2. When the assets of an A, B, or D SSI recipient are combined with those of an F or C family unit, such as in a savings account, decide the portion of the asset available to the F or C household as follows:

a. If the asset is jointly owned, divide the value equally among the owners.

Account: A contract of deposit of funds between depositors and a financial institution. This includes checking and savings accounts, certificates of deposit, share accounts, etc.

b. If you can identify exempt funds, such as a lump sum SSI payment which is exempt for 6 months after receipt, do not count them until after the exempt period has expired.

409.2 Joint Ownership of Assets

If property is owned by more than one person, determine the client's share. Plural ownership can exist in different forms.

In Utah these are:

1. Joint-tenancy.
2. Tenancy-in-common.
3. Not specified. The property is simply recorded in the names of 2 or more persons. Ownership is tenancy-in-common unless stated to be otherwise.

In all 3 cases, each owner has the legal right to sell only his share of the property. Unless there is a condition of ownership specifically prohibiting sale of any part of the asset without permission of the other owners, the client's share is an available asset. If there is such a condition, see Sec. 409.3.

However, when other owners refuse to sell the property, the fair market value of the client's share may be reduced. In such a case, allow the client to refute the determination of his equity by providing a statement from a knowledgeable source documenting the fair market value of the client's share based on the particular circumstances of the case.

The laws on plural ownership may differ for property located in other states. If you have a case with property in another state under plural ownership, contact the State APA Office.

409.3 When Legal Factors Hinder Making an Asset Available

1. If legal factors hinder making the asset available, it is exempt until it can be made available. (See 2 below). For example, a condition of ownership may prohibit selling the asset without the consent of both parties. In this case, the asset is exempt until the condition of ownership is changed or both parties consent to the sale.

2. If an asset is not legally available but can be made available by client action, the client must take steps to make it available. There are 2 exceptions. These are:

a. It is doubtful that reasonable actions will succeed. This should be confirmed by a knowledgeable source, such as a lawyer or financial institution.

b. The likely cost of making the asset available exceeds its value.

If 2a or 2b applies, explain this in the case log and do not count the asset. Otherwise, require the client to take all reasonable steps to make the asset available. The asset is exempt while these steps are being taken.

For applicants, such steps must begin before the application is approved. For ongoing cases, such steps must begin before any more assistance is issued, provided 10 day notice can be given. If such steps are not taken, or if the client does not follow through with the process, close or deny the case.

409.4 Transfer of Title

1. Vehicles — including motor vehicles, trailers, etc.

Unless you have reason to question ownership of a vehicle, accept the bill of sale or other legal document as proof of ownership. When questioning ownership, remember that until the Department of Motor Vehicles issues a new certificate of registration and certificate of ownership, the transfer of title is incomplete.

If transfer is incomplete, legal ownership is retained by the original owner and the vehicle is available to him alone, and not to the new owner.

If transfer is complete, legal ownership is with the new owner.

2. All Other Property with a Title Document.

When the client states property has been sold, but the title document has not been transferred, contact the State APA Office to determine the availability of the property. Send all documents relating to the property and the transfer. Be sure to include any conditions attached to the transfer.

If the State APA Office determines that the asset is not available because title has not been transferred, follow the rules in Sec. 409.3.

409.5 Divorce Decrees

Review divorce decrees on a case-by-case basis.

1. Before a divorce is final:

The filing of a divorce petition does not change the ownership or availability of assets unless there is a court order specifically dealing with the assets. Unless there is such a court order, base availability on the ownership prior to the filing of the divorce petition.

If there is a question of an asset's availability after viewing the court order, contact the State APA Office.

2. After a divorce is final:

a. When there is no title document, a divorce decree can transfer legal title of personal property. But be sure to check for conditions attached to the transfer: liens, conditions concerning remarriage, etc. These conditions may restrict the sale of the asset. If so, see Sec. 409.2-2.

b. In cases of property where there is a title document, be sure the title has been transferred. Again, be sure to check for conditions attached to the transfer. If title has not been transferred, see Sec. 409.4.

409.6 Trusts

The rules which follow are guidelines to help you determine the availability of trust funds. Sometimes you will have to get more information or a legal opinion about trust funds. This can occur even when you have complete documentation. In these cases, be sure to send a copy of the trust agreement to the State APA Office for a decision about the availability of the trust.

409.61 Definitions

1. Trust: A right of property held by one party for another.

2. Trustee: The person who holds the legal title to property for the benefit or use of another.

3. Beneficiary: The person for whose benefit the trust is created. Although this person does not hold legal title, he does have an ownership interest.

The beneficiary can receive money from the trust directly or through the trustee.

409.62 Availability to the Trustee

1. The entire trust is available as an asset if the client is the trustee and has the legal ability to:

a. Revoke the trust, and

b. Use the money for his own benefit.

2. The entire trust is available if:

a. The trust was created by the client or his spouse, and

b. The client or his spouse has the right to dissolve the trust, and

c. He can use the money for his own benefit.

3. In all other cases, the trust is not available to the trustee.

409.63 Availability to the Beneficiary — All Cases

If the client is the beneficiary and access to the trust is not restricted, the full value of the trust is an available asset. If access is restricted, see 409.64 and 409.65 below.

409.64 Trusts Set Up for Purposes Other Than to Qualify for Medicaid — Created by the Client or His Spouse — *All Cases*

1. With the exception of burial trusts, these rules apply to all trusts, including irrevocable trusts.

2. Potential payments in the budget month from the trust are an available asset if the client or his spouse set up the trust. The value of the asset is the maximum amount that the trustee can disburse to the client when exercising his full discretion under the terms of the trust. It does not matter whether disbursement is actually made. The potential disbursement can include both income and principle of the trust.

409.65 Trusts Set Up for Purposes Other Than to Qualify for Medicaid — Created by Someone Other Than the Client or His Spouse

For A, B, and D Cases

If the client's access to the trust principle is restricted*, the principle is not an available asset. This is true even when the trust:

1. Can be revoked by someone other than the beneficiary, and

2. Provides a regular payment from the principle to the beneficiary.

Payments made to the client from the trust are income.

For F and C Cases

The principle is an available asset if there is access to the principle to meet the needs of a household member. It does not matter if access is restricted. If the only way to access the trust is by approval of the court, require the client to petition the court to release the funds in the trust. Follow the procedures in Sec. 409.3.

When disbursement is limited to specific and limited needs or the principle cannot be invaded, the trust may not be available. (See 409.68.)

For example, when disbursement of funds of a trust set up from an insurance settlement is legally limited to payment of medical bills arising from an accident, the trust is not available. However, forward information about the trust to ORS. In this case, there is TPL coverage ORS must pursue.

409.66 Trusts Set Up for the Purpose of Qualifying for Medicaid

When it appears that a trust has been established to allow the beneficiary to qualify for Medicaid, submit the trust document and all other pertinent information to the State APA Office for a decision on the availability of the trust.

Restricted Access: Only the court or the trustee, who is not the beneficiary, or the beneficiary's spouse or parent, can invade the principle of the trust.

409.67 Trusts Set Up to Pay For Medical Expenses Related to Organ Transplants

Send a copy of all trust set up to pay expenses related to organ transplants to the State APA Office for a decision regarding the availability of the trust.

409.68 When Availability is Not Clear

When you cannot determine whether all or part of a trust is available, submit it and all other pertinent documents to the State APA Office for a decision.

R810-304-411. Exempt Assets.

Allow the following exemptions for medical assistance cases other than Indigent Medical cases. See Section 807 for exemptions specific to Indigent Medical cases. If an asset is not treated in that section, use the F or C policy.

1. One Home and Lot — All Cases

Exclude one home, including a mobile home, and lot owned or being purchased and occupied by the client.

a. F and C Cases — The lot on which the home stands shall not exceed the average size of residential lots in the community where it is. Count the equity value of property exceeding an average size lot.

b. A, B and D Cases — Exempt the home and all contiguous property.

Exempt a life estate in a home if the owner of the life estate continues to live in the home.

2. One Home and Lot of a Person Who is A Resident of a Medical Institution — All Cases

When a person who owns a home, or life estate in a home, becomes a resident of a medical institution, the home or life estate becomes countable unless:

a. The person's stay in the medical institution will be short term. A stay is short term if a doctor says that the client is likely to return home within 6 months of admission. Anyone in a medical institution more than 6 months after admission is long term, or

b. The person states that he intends to return home. It does not matter whether the person actually returns home within 6 months. There is no time limit to this exemption. The statement of intent must be in writing from the client or his representative, or

c. The person has a spouse, dependent child, or relative* who lives in the home.

3. Water Rights — All Cases

Exclude water rights attached to a house and lot.

Relative: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister

4. Household Goods and Personal Effects

F and C Cases

Exclude the contents of the home that are essential to daily living. However, individual items with an value over $1,000 must be counted against the asset limit.

A, B, and D Cases

Exclude household goods and personal effects only to the extent they do not exceed $2,000.

a. In developing this $2,000 limit, if there are no single items with a value (as can be currently sold) of $500 or more, then do not consider the $2,000 exempt amount to be exceeded.

b. If there are single items with a value of $500 or more, then consider all other household goods and personal effects to have a value of $1,000. Add the single item(s) of $500 or greater value to $1,000, and then count the amount in excess of $2,000 towards the household's asset level.

5. Vehicles

F and C Cases — Exclude the equity value up to $1,500 of one car or other motor vehicle used to provide transportation for the assistance unit. Count any equity value in excess of this amount towards the household's asset limitation.

A, B, and D Cases — Exclude one vehicle, regardless of value if:

a. It is necessary for employment; or

b. It is used at least four times per calendar year for obtaining medical treatment; or

c. It is modified for use by a handicapped person.

d. It is needed due to climate, terrain, distance or other such factors to provide transportation for essential daily activities.

If no vehicle is excludable for one of the above reasons, one vehicle may be exempt if its fair market value does not exceed $4,500. If its fair market value exceeds $4,500, then count the amount in excess towards the asset limit.

Count the equity value of all other vehicles towards asset limits.

6. Irrevocable Burial Trust — All Cases

a. Exempt the value of an irrevocable burial trust fund such as a pre-arranged funeral plan.

b. Additionally, only the value of an irrevocable burial trust is used to reduce the burial/funeral fund exemption (see Sec. 411, (9)).

7. Life Insurance

A, B, and D Cases

a. Whole life insurance policies are exempt if the total face value of all such policies does not exceed $1,500 per individual. If their total face value exceeds $1500 for any individual, count the cash value of all that individual's policies against the asset limit. Up to $1,500 of the cash value can be exempt if it is used as a burial/funeral fund (See 411-9 below). Term insurance policies have no cash value, are not resources, and are not used in any way in determining countable assets.

b. Whole life insurance which is exempt must be deducted from the exemption level of burial/funeral funds (see Sec. 411, (9)).

Note: The cash value shown on the insurance policy table includes some interest. Often the interest paid on the cash value is greater than that used to compute the table. Therefore, the table may not show the true cash value. This is especially likely in cases of policies that have been held for a long time. When there is countable cash value that, combined with other assets, puts the assets close to the limit, you should obtain a current statement of the cash value.

F and C Cases

Count the cash value of life insurance policies.

8. Burial Spaces — All Cases

a. Exempt burial spaces and any items related to repositories used for the remains of the deceased, for any member of the client's immediate family. This includes caskets, concrete vaults, crypts, urns, grave markers, etc. Also, if a client owns a grave site, the value of which includes opening and closing, the value of these services is also excluded.

b. A burial contract or funeral plan may include many of the items exempted in this section. However,

these types of contracts are merely promising these items when needed (a plot, a casket, a marker, etc.) and are considered to be a part of the contract or plan. They are not evaluated separately. They are considered for exemption under Section 411, (9).

9. Burial/Funeral Fund — All Cases

Allow a $1,500 burial or funeral fund exemption for each eligible household member. Compute this burial or funeral fund exemption as follows:

a. First, subtract the value of any irrevocable burial trust from the $1,500 burial or funeral fund exemption. If the irrevocable burial trust is valued at $1,500 or more, it will reduce the burial or funeral fund exemption to zero. If that is the case, do not go on to steps b. and c. The amount of the irrevocable burial trust which exceeds $1,500 is not counted as an asset.

b. Second, for A, B and D categories only, reduce the remaining burial or funeral fund exemption by the total face value of any exempt whole life insurance policies. If the face value of these policies exceeds the remaining burial or funeral fund exemption, it will reduce the burial or funeral fund exemption to zero. If that is the case, do not go on to step c. The amount of face value which exceeds the remaining burial or funeral fund exemption level is not counted as an asset. This step does not apply to F and C categories as life insurance is already counted.

c. If after subtracting the value of the irrevocable burial trusts and face value of exempt whole life insurance policies there is still a balance in the burial or funeral fund exemption, reduce the remaining exemption level by the cash value of any burial contract, funeral plan, and/or funds set aside for burial.

d. In A, B, and D cases only, subtract the cash value of non-exempt life insurance policies.

e. If these reductions result in an exemption greater than $1,500 then the difference is to be added to the other countable assets.

(1) Any interest which is accrued on an exempt burial contract, funeral plan, or on funds set aside for burial are exempt from consideration as an asset or as income.

Funds set aside for burial: funds which are separately identified and not commingled with other funds. They must be clearly designated so that an outside observer can see that these funds are specifically for the client's burial expense.

(2) If a person ever removes the principle or interest from an exempt burial contract, funeral plan, funds set aside for burial, or a life insurance policy and uses the money for a purpose other than for their burial expenses, the amount withdrawn from the account must be counted as income. The amount remaining in the fund is still exempt.

If a client has a previously unreported resource which he claims is to be used for burial:

(a) and the resource is clearly designated as being for burial, evaluate it for exemption back to when it was either designated or intended for burial. However, the date cannot be before November 1, 1982 and cannot be any earlier than 2 years prior to the date of application.

(b) and if the case is A, B, or D case and the resource is not clearly designated as being for burial, it can be designated for burial retroactively back to the first day of the month the client intended to set it aside for burial. However, the date cannot be before November 1, 1982 and cannot be any earlier than 2 years prior to the date of application.

10. Land or Accounts Held in Trust — All Cases

Exclude ownership of beneficial interest in any land or account which is held in trust by the United States, a state, or in a tribal account.

11. Per Capita Tribal Payments

Exlude all per capita payments or any asset purchased with per capita payments made to a tribal member by the Secretary of the Interior or the tribe.

12. Alaska Native Claims Settlement Act — All Cases

Exclude shares received as payment under the Alaska Native Claims Settlement Act (Public Law 92-203).

13. Income Producing Property — A,B, and D Cases

Exclude income producing property from assets when the individual's equity in the property does not exceed $6,000 and the property produces a net annual return of at least 6 percent of the equity. Count any equity value in excess of $6,000 only if the 6 percent net annual return* is met. If it is not then count the entire equity amount.

Net annual return: The income produced after subtracting mortgage payments or other payments necessary to generate income.

14. Retroactive Social Security Benefits — All Cases

Exempt lump sum retroactive benefits received from the Social Security Administration (SSA and SSI) for 6 months after the month of receipt.

15. Student Benefits

All Cases

Do not count monies from certain sources to undergraduate students as assets. These sources include:

a. Educational loans, grants or scholarships that have funds guaranteed by the U.S Commissioner of Education, including:

— Pell Grants (Formerly BEOG)
— Supplemental Educational Opportunity Grant (SEOG)
— National Direct Student Loans (NDSL)
— Guaranteed Student Loans
— State Student Incentive Grants (SSIG)

b. Payments to participants of a service learning program, such as College Work Study or University Year for Action (UYA).

A, B, and D Cases

Count any monies which remain after the school period covered from an educational grant, loan, or scholarship as an asset.

16. Pension Funds — A, B and D Cases

Do not count money held in a retirement fund under a plan administered by an employer or union, an individual retirement account (IRA), or Keogh account owned by a spouse or parent ineligible for A, B, or D medical.

a. Count as an asset any available money withdrawn from the pension starting the month after it is withdrawn.

17. Uniform Gifts to Minors Act (UGMA) — All Cases

Do not count any asset, or the interest from the asset, which is held within the rules of the Uniform Gift to Minor's Act (UGMA). Count any money from the asset given to the child as unearned income.

Uniform Gift to Minors Act: An irrevocable gift of money or property to a child under the age of 21. The gift can be made to only one child, with only one custodian. The gift is verified on a specific form which includes a statement that the custodian holds the asset for the child under the Utah UGMA rules.

18. Cash Payments Given to Help Pay for Medical or Social Services.

For A, B, and D Medicaid, exclude cash payments from federal, state, or local government programs if the purpose of the payment is so the client can pay for medical or social services. This includes payments for vocational rehabilitation. Exclude these payments only for one calendar month following receipt. Do not confuse this exemption with reimbursements for medical or social services; money received as reimbursement must be counted as a resource the first month following receipt.

R810-304-419. When to Deem Assets.

Spouses have a legal responsibility to financially support one another. Parents have a legal responsibility to financially support their children until they are emancipated*. Because of this legal responsibility, assets from a spouse or parent are counted as available to the eligible spouse or child. This process is called deeming. Because the asset is available, include it in the countable assets.

419.1 Non-Nursing Home Cases

Deem only from spouse to spouse or parent to unemancipated child. Deem only among people who live together.

419.12 F and C Cases

Do not deem from a parent or spouse who gets SSI.

419.2 Clients Who Are Residents of Medical Institutions

Do not deem to a resident of a medical institution. However, there may be persons in medical institutions who are not treated as medical institution cases. These cases will be set up using policy for clients who are not residents of medical institutions: deeming may apply. Examples are:

1. F or C Cases — Persons who are temporarily living apart from their parents or children are not considered residents of medical institutions.

2. All Cases — Persons are not considered residents for the month they enter the medical institution.

419.3 All Cases

Exemptions for deemed assets are applied based on the type of asset (home, burial funds, tribal funds, certain lump sum payments etc.), and the category of assistance to which it is being applied. Emancipated: A child is emancipated by:

1. turning 18 years old, or
2. getting married, or
3. getting a court order which says that the child is emancipated.

R810-304-421. Lump Sum Payments — All Cases.

Remember that most lump sums count as income in the month they are received. Count as an asset any balance which remains the month after receipt. All SSA and SSI lump sums are exempt for 6 months after receipt.

421.1 Lump Sum Received on Sales Contract

1. Exempt lump sum payments received on a sales contract for the sale of an exempt home if the money is committed to replacement of the property sold within thirty days and the purchase is completed within ninety days.

a. If a period longer than ninety days is required to complete the actual purchase, the District Director may grant an extension in writing, using Form 689, Policy Decision.

2. If the property is not replaced within 90 days and no extension has been granted, consider the total payment received as an asset.

421.2 Proceeds Other Than or In Addition to a Lump Sum

1. Proceeds of a sales contract other than or in addition to a lump sum shall be exempt if applied to the purchase of replacement property. The same conditions of time and commitment as for a lump sum apply (see Sec. 421.1).

2. If proceeds from the contract are not to be used to replace property, consider the balance remaining on the sales contract as an asset.

3. Availability (at any amount which would result in excess assets) is a factor. This means that if the balance remaining on a sales contract can be discounted to an amount which (in conjunction with any other countable assets) exceeds the asset level, the client is ineligible.

Example:

Assume a single individual has no other countable assets, but has a balance remaining on a sales contract of $5,000. We would ask a financial institution or other knowledgeable source if a market exists to assign the balance remaining to a buyer for the one-person asset limit. If the market exists, then the balance remaining on the sales contract would make the client ineligible.

421.3 Insurance Settlements for Destroyed Property

Exempt lump sum insurance payments for destroyed property if the available money is used within ninety days to replace the destroyed property, and the destroyed property was exempt at the time of loss.

1. The District Director may grant an extension beyond ninety days, using Form 689, Policy Decision.

R810-304-425. Income Producing Property.

425.1 F And C Cases

When a client owns property and has the legal right to sell it without interference, the property is available and we will count it in determining eligibility.

425.2 A, B and D Cases

1. Exempt income producing property when:

a. The equity in the property is less than $6,000 and

b. The property produces a net annual return of at least 6 percent of the equity.

Equity value more than $6,000 counts as an asset only if the 6 percent net annual return is met. If it is not, then the entire equity amount shall count.

2. If the client has the legal right to sell his share of the property, and if such equity is includable as an asset, and this results in the asset level being exceeded, close the case or deny the application.

3. The actual availability (whether a market exists to sell the property) is not a factor in counting the property as an asset.

R810-304-431. Transfer of Excess Assets.

431.1 F and C Medicaid

Take no sanction on the transfer of any asset.

431.2 A, B, and D Medicaid — Clients Who Are Not Residents of Medical Institutions.

Take no sanction on the transfer of any asset if the client is not a resident of a medical institution.

431.3 A, B, and D Medicaid — Clients Who Are Residents of Medical Institutions

431.31 Apply no sanction for the transfer of the following assets:

1. If the property was transferred prior to July 1, 1988 and the property was transferred more than 24 months prior to the date of application. Also, apply no sanction for the transfer of an asset which would have

been exempt by Medicaid rules in effect at the time of the transfer.

2. If the property was transferred on or after July 1, 1988 and the property was transferred more than 30 months prior to the date of application. Also apply no sanction in the following situations:

a. Transfer of a home to a spouse

b. Transfer of any resource to a spouse or for the sole benefit of a spouse

c. Transfer of a home or other resource to a child under age 18 who is blind or permanently and totally disabled

d. Transfer of a home to a sibling who has an equity interest in the home and who has lived in the home for at least 1 year immediately preceding the client's entry into a medical institution

e. Transfer of a home to a son or daughter who has lived in the home and cared for the client for at least two years prior to the individual's entry into the medical institution.

431.21 Undue Hardship

Apply no sanction for transfer of assets if the sanction would be an undue hardship on the client. An undue hardship exists when:

1. The client has exhausted all reasonable legal means to regain possession of the asset transfarred. It is not reasonable to require the client to take action if a knowledgeable source (such as the client's lawyer or financial institution) confirms that it is doubtful those efforts will succeed. That knowledgeable source must specify the reasons for that decision. The worker or supervisor must agree that it is doubtful those efforts will succeed. (Workers may contact the State Office of Assistance Payments for advise or assistance if needed.) It is not reasonable to require the client to take action more costly than the value of the asset, and

2. Either "a" or "b" below

a. Without Medicaid, the client will not be able to enter a nursing home and the client is at risk of death or permanent disability if not admitted to a nursing home. This must be verified by a physician's statement.

b. This household cannot afford to meet the client's medical needs at home. The client must verify that the cost of medical care (including diapers and special foods) added to normal living costs, exceeds household income. Do not count medical costs that are covered by insurance. If the client is eligible for Medicaid, do not count medical costs covered by Medicaid but count any spenddown required.

431.33 Rebuttal of Presumption the Resource Was Transferred to Become Eligible for Medicaid

Presume that any transfer of assets at less than current market value is for the purpose of meeting asset limitations. It is the client's responsibility to provide evidence that a transfer was made for exclusively another purpose. Apply no sanction if the client verifies this.

431.34 How to Apply the Sanction

1. Determine if the current market value* (at the time of the transfer) was received. Form 421 may be used to contact a knowledgeable source to aid in this decision. Do not consider the services of or assistance of a family member in exchange for property unless a contract existed prior to the receipt of the service.

2. If the asset transfer occurred after July 1, 1988, the period of ineligibility begins with the month in which the resources were transferred. The client is ineligible for the less of:

a. 30 months, or

b. The number of months resulting from dividing the total uncompensated value* by the average private-pay rate for nursing homes. This is $1,365.

Current Market Value: A fair and reasonable compensation (in money or other worth) for property as established by current standards of appraisal. Uncompensated Value: The difference between the current market value of property and the lesser compensation received as a result of the transfer. When an asset was jointly owned the uncompensated value is the difference between the individuals shares of the current market value and the compensation received.

3. If the asset transfer occurred before July 1, 1988, add the uncompensated value to all other countable assets for a maximum of 24 months from the date of transfer. The household is ineligible as long as the asset level is exceeded. Uncompensated value may be reduced as follows:

a. During months not eligible for Medicaid — reduce uncompensated value by incurred expenses as listed in Section 309.31.

b. During months eligible for Medicaid — reduce uncompensated value by any spenddown paid and any incurred expenses as listed in Section 309.32.

431.5 Determination of Current Market Value in Transfer of Property

To determine whether property was transferred for Current Market Value, add to the amount received by the seller any debts against the property.

To determine the proceeds from the transfer of property, subtract from the sale price any unsatisfied mortgage, any burial expense paid within the prior 3 months, and any medical expense paid within the prior 6 months.

431.6 Life Estates as Assets

A, B and D Medicaid

When an applicant/recipient transfers property to another party and retains a life estate* interest, consider the transfer according to the policy requirements for transfer of assets.

If the transfer of assets provisions are met, proceed as follows:

1. Determine the current market value of the property by contacting a knowledgeable source which include:

a. Real Estate brokers.

b. The local office of the Farmer's Home Administration (for rural land).

c. The local office for the Agricultural Stabilization and Conservation Service (for rural land).

d. Banks, savings and loan associations, mortgage companies, and similar lending institutions.

2. Use Table VI.

3. Find the claimant's age as of last birthday.

4. Multiply the figure in the life estate column for that age by the current market value of the property to determine the value of the life estate.

5. If the value of the life estate in conjunction with any other countable assets exceeds the allowable asset level, close the case or deny the application.

a. Count the value of the life estate even if no market exists to sell it.

6. If the client refutes the above amount, use the new amount as verified.

F and C Cases

Do not consider the life estate interest as an available asset. However, count any income produced by the life estate.

Life estate: a life estate conveys upon an individual or individuals for his lifetime certain rights in property. The owner of a life estate has the right of possession, the right to use the property, the right to sell his

life estate interest. He does not have title to the property and he does not have the right to sell the property itself.

R810-304-441. Third Party Liability (TPL) — All Cases.

Applicants for medical assistance must, as a condition of eligibility, cooperate in the completion of the Third Party Liability Questionnaire. Recipients of medical assistance must report any changes in third party liability and they must cooperate in the establishment and collection of third party claims. This includes cooperating in the establishment of paternity so third party claims can be established against the absent parents.

441.1 Changes in TPL Information

The recipient must report changes in TPL information no later than 30 days after the change. To do this, the recipient may use the Form 61-B, a monthly report form, or another method such as a phone call.

When the district receives a report of a change in TPL information, the district worker must complete a new TPL Questionnaire and send it to the cost avoidance unit. If the district receives the report more than 30 days after the change in TPL, make a note of this on the TPL questionnaire that is sent to the Cost Avoidance Unit (CAU) at ORS.

In addition, whenever the District Office receives information indicating possible TPL arising from negligence of others, such as automobile accidents, public liabilities, homeowner's accidents, etc, ORS should be notified by memo of the following:

a. Recipient name and case number

b. Date of the accident

c. Nature of the accident

d. Any other pertinent information, such as the company involved, policy holder, and court information.

Remember that money received from a TPL source is not to be counted as income against medical liability.

Third Party Liability: An individual, institution, corporation, public or private agency that is responsible or may be responsible to pay all or part of the medical cost of injury, disease, or disability of an applicant or recipient. Examples of third party liability include health, accident, and hospital insurances; liability insurance such as auto and homeowner's policies; industrial accident claims; court judgments, and rights to medical support a child might have from an absent parent.

441.2 Sanctions for Noncooperation

Noncooperation is refusing to complete the TPL form or withholding TPL information that is available to the client.

If a person provides all the TPL information of which he is aware but doesn't know every detail, this is cooperation. If a third party, such as an ex-spouse, refuses to tell the client about insurance information, this is cooperation.

Only the CAU in Recovery Services will have the responsibility for determining noncooperation. If the client has good cause for noncooperation*, impose no sanction.

If the CAU determines that a client is not cooperating, it will notify the district office. After providing the 10-day advance notice, withhold medical assistance only for the individual who refused to cooperate.

The CAU will notify the district office when the client begins cooperating. Restore medical coverage for the full month in which notice of cooperation is received.

Good Cause for Noncooperation: Good Cause for noncooperation includes the reasonable anticipation of physical or emotional harm to the applicant, recipient, or children.

R810-304-443. Eligible Aliens and Counting The Assets of Sponsors — All Cases.

Certain aliens who have been legally admitted in the United States for permanent residence must have the resources of their sponsors considered in determining eligibility for medical assistance.

443.1 Aliens Who are Not Subject to This Requirement

Aliens who are not subject to this requirement are those who are:

1. Paroled in the US as refugees
2. Granted Political Asylum
3. Admitted as Cuban/Haitian entrants
4. Other conditional or paroled entrants
5. Not sponsored or who have sponsors that are organizations or institutions
6. Sponsored by persons who receive medicaid, AFDC or SSI
7. The dependent child of the sponsor
8. The sponsor's stepchild

There are some permanent resident aliens who have I-151's or I-551 (or "green cards") and who were admitted to this country as refugees. These people are not subject to this requirement.

443.2 Aliens Who are Subject to this Requirement

Aliens who apply for medical assistance after April 1, 1983 and who have been legally admitted into the US for permanent residence are subject to this requirement. They are subject to this for 3 years after their "entry" date into the United States. This entry date has been defined as the date established by INS as the date the alien was admitted for permanent residence. Time spent in the U.S. under other than permanent residence is not considered as part of the 3 year period.

Sponsor: any person who has completed an affidavit or other similar agreement with the Immigration and Naturalization Service (INS) on behalf of an alien as a condition of the alien's entry into the US for permanent residence.

Aliens who are subject to this requirement will have either an INS Form I-151 or INS Form I-551.

443.3 Reporting Assets of Sponsors

1. The sponsor's assets must be reported each month. The report must include a written statement of the sponsor's assets. The statement must be signed by the sponsor.

2. The sponsor's statement must be received by the 17th of the month or the alien's case must be closed.

443.4 Countable Assets of Sponsors

To determine how much of the sponsor's assets to count in determining eligibility for the alien, follow these steps

1. Apply the medical assistance policies (see section 400) to the assets of the sponsor and the sponsor's spouse.

2. Subtract $1,500 from the countable assets of the sponsor and sponsor's spouse.

3. Count the remaining asset value in determining the alien's eligibility.

443.5 Multiple Sponsorships

1. When a person sponsors two or more alien families living together, the countable assets of the sponsor will be divided equally among the aliens.

2. When a person sponsors two or more alien families who do not live together, the countable assets per *family will depend on the number of alien families* who receive medical assistance.

Example: a person sponsors four alien families, but only one is eligible for medical assistance, the total countable assets will count against that one alien family.

Example: a person sponsors four alien families and three of them are eligible for medical assistance, the total countable assets would be divided equally among the three eligible alien families.

443.6 Revocation of Sponsor Agreements

Do not waive these requirements even if the sponsor claims to have revoked his sponsorship agreement.

R810-304-461. Whose Assets to Count — Clients Who Are Not Residents of Medical Institutions.

See Sec. 209.2 for a definition of a medical institution. See Sec. 365.1 for a definition of a resident of a medical institution.

461.1 For an Emancipated Child

When a child is emancipated*, count only his assets.

461.2 For an Unemancipated Child

1. Count the income and assets of a child's parents when the child lives with his parents.

For B and D cases, a child is considered living with his parent until the month after he moves.

For F and C cases, a child is considered living with his parents while temporarily absent from the home, such as for school, vacation, summer employment, medical treatment, etc. One exception to this rule is a child in the custody of a State agency, such as a Youth Corrections detention center or Utah State Training School. The court order will say that the child is in the custody of the State.

2. Count only the assets of the child when:

F and C cases — when the child is living away from his parents and it is not temporary.

a. This includes a child receiving Title IV-E Foster Care assistance, no matter where he lives.

b. This includes a child in foster care who has not been placed back in his own home (See Sec. 213.5) The only exceptions to this are (1) a child voluntarily placed in foster care and who is not eligible for Title IV-E Foster Care assistance and (2) a child in the custody of a state agency. In these cases, the parents' income and assets must be counted because they have signed an agreement to provide medical care for the child.

c. This includes a child living with a specified relative if it is not temporary.

Emancipated: A child becomes emancipated by:

1. Turning 18 years old.
2. Getting married.
3. Obtaining a court order that specifically states the child is emancipated.

d. This includes a child temporarily placed in an institution if the state is responsible for the care and control of that child. The state is responsible for control and care of the child if a court order places the child in the custody of the state. The state is also responsible for the child if the parents have voluntarily relinquished parental rights.

461.3 Countable Assets for a Spouse

Count the assets of a spouse as available to his spouse while the couple lives together.

For A, B, and D, Cases

If a couple separates, and if each spouse gets Medicaid, count the assets of the spouse as available for 6 months following the separation. If they get divorced in the 6 months, quit counting the assets.

If a couple separates, and if only one spouse gets Medicaid, quit counting the assets of the ineligible spouse starting the month after they separate.

For F and C Cases

If a couple separates, and the separation is not temporary, count only the assets of the eligible spouse.

R810-304-465. Whose Assets to Count — Clients Who Are Residents of Medical Institutions.

See Sec. 209.2 for a definition of a medical institution. See Sec. 365.1 for a definition of a resident of a medical institution.

Remember that when a person who owns a home becomes a resident of a medical institution, the home becomes countable unless:

1. The person's stay in the medical institution will be short term. A stay is short term if a doctor says that the client is likely to return home within 6 months of admission. Anyone in a medical institution more than 6 months after admission is long term, or

2. The person states that he intends to return home. It does not matter whether the person actually returns home within 6 months. There is no time limit to his exemption. The statement of intent must be in writing from the client or his representative, or

3. *The person's spouse or dependent children or a* relative* who still live in the home.

465.1 A, B or D Cases

Count only the assets of the client. Compare them to the asset level for one person.

465.2 Assets for a Child Who is a Member of an AFDC Household — F Cases

When the child is expected to return to the AFDC household, continue him as an additional on that case.

When the child is not expected to return to an AFDC household consider another category of coverage for him.

465.3 Assets for a Parent Who is a Member of an AFDC Household — F Cases

When the parent is expected to return to the AFDC household, continue him as an additional or as the payee on that case.

If the parent is not expected to return to the AFDC household, he is not eligible for F category. Consider another category of coverage.

Relative: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half sister, half brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister

465.4 Assets for a Child Who is Not a Member of a F Category Household — C Cases

See Sec. 209.2 for a definition of a medical institution. See Sec. 365.1 for a definition of a resident of a medical institution.

If the child can be expected to return home, he is still considered part of the C case. Do not treat the child as a resident of a medical institution. Treat the entire household as a case involving clients who are not residents of a medical institution.

If the child is not expected to return home, do not consider him a resident of a medical institution for the month he leaves home. For following months, count only the child's assets.

465.5 Assets for a Foster Care Child Who is a — F or C Cases

Count only the child's assets. Compare them to the asset level for a one person.

465.6 Accumulated Assets of Residents of Medical Institutions — All Categories

1. If a resident of a medical institution accumulates assets in excess of the asset limit, close the case even if costs of the medical institution are to be paid from these monies. However, do not count as an asset any deposit to savings or checking accounts in the same month that you count the deposit as income.

2. During eligibility determinations and reviews examine personal need accounts. Add any amount in excess of $30 to other countable assets.

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R810-305. Medicaid: Program Benefits.

R810-305-503. Basic Maintenance Standard.
R810-305-507. Medical Identification Card.
R810-305-511. Date of Entitlement.
R810-305-521. Availability of Medical Services.
R810-305-561. Burial Allowance.

R810-305-503. Basic Maintenance Standard.

The Basic Maintenance Standard shown on Table II Grants, is the base to which countable income is compared to determine if a household has excess income.

R810-305-507. Medical Identification Card.

Except for recipients of the Indigent Medical Program, an identification card shall be issued each month listing the eligible members of the household and indicating any additional medical insurance coverage available to them which might limit the responsibility of the State for payment for the services.

1. To obtain medical services, the individual must present this identification card to the medical provider of his choice.

2. A medical identification card shall only be computer printed.

507.1 Interim Medical Eligibility

If medical services are needed by an approved applicant before a computer-issued identification card is received, the District Office shall use Form 695, Interim Verification of Medical Eligibility, to inform the medical provider of the claim procedure.

R810-305-511. Date of Entitlement.

Assistance shall be effective from the first of the month of application if the case is determined to have been eligible at any time during the month. However, for A, B or D Medicaid, when assets held on the first day of a calendar month exceed allowable limits, the household is ineligible for the entire month.

2. If the District Assistance Payments Office determines during the verification process that the applicant was ineligible on the date of application but later in the month, became eligible, assistance shall begin on the first day of the month the application was made.

3. If a newborn child is a member of an AFDC financial assistance household, then add him to the grant, after verification requirements are completed, effective the date the birth is reported to the District Office. However, the child is eligible for medical coverage effective the date of the birth.

511.1 Retroactive Medical Assistance

If payment of past medical expenses is requested retroactive medical assistance may be approved if the following conditions are met:

1. The Medical expense must have been incurred no earlier than the first day of the third month prior to the month of application.

2. Individuals not eligible during the month of application may still be eligible for any or all of the retroactive months.

3. The household must be determined to have been eligible the month the expenses were incurred.

4. The excess income amount shall be determined for each requested retroactive month in which a service was provided which cost exceeds the excess income for the same month.

5. The excess amount for any eligible retroactive month must be paid before any medical benefit may be approved. The applicant pays only for those months he wishes to be covered.

6. For AFDC-PG, do not allow retroactive coverage for the 2 months of eligibility following the termination of the pregnancy. This coverage is allowed only when the client received Medicaid at the time the pregnancy terminated.

511.2 Retroactive Assistance for Clients in Medical Institutions

Use the same procedure to determine eligibility and any excess income for a patient in a medical institution as for any other applicant. For retroactive Medicaid after October 1, 1988, the client must pass the Gross Test for coverage of nursing homes, Utah State Hospital, or Utah State Training School. (See Sec. 361.1)

511.3 Nursing Home Date of Eligibility

Although the date of medical eligibility is established in the district office, it is only part of the process necessary to pay a nursing home. The date of medical eligibility (always the first of a month) can be different from the date of eligibility for payment. This is because the nursing home stay needs to be authorized as medically necessary. This is done by the Bureau of Patient Assessment in the Division of Health Care Financing. HCFA Form 10 (Preadmission Document and Continued Stay Transmittal) is used for this purpose. Since Health Care Financing will not pay the nursing home for coverage prior to the date on the Form 10, this may be a different date than the first of a month.

Tell the client or his representative that this two part eligibility exists, so that when a 228C is received, it is not mistaken for the only factor which influences payment to the nursing home.

R810-305-521. Availability of Medical Services.

An individual may seek medical care anywhere within the State; however, the individual is encouraged to seek the nearest available medical care.

521.1 Out-of-State Medical Services

1. Requests for out-of-state medical services must be made to the State Assistance Payments Office for prior approval through the Division of Health Care Financing.

2. There are 4 areas in Utah where medical services may be obtained out-of-state with out prior approval.

a. Rich County residents may go to Evanston, Wyoming; Riverton, Wyoming; Preston, Idaho; Paris, Idaho; or Montpelier, Idaho.

b. San Juan County residents may go to Cortez, Del Norte, Dolores, Durango, Grand Junction and Montrose, Colorado; or to Shiprock or Farmington, New Mexico.

c. Residents of the Snake Valley area in Millard County (Garrison, Gandy, Burbank and Eskdale) may go to Ely, Nevada and East Ely, Nevada.

d. Residents of Grand County may go to Grand Junction, Colorado.

Note: Long term care can be provided only in Utah.

§ 1382b. Resources

(a) **Exclusions from resources.** In determining the resources of an individual (and his eligible spouse, if any) there shall be excluded—

(1) the home (including the land that appertains thereto);

(2)(A) household goods, personal effects, and an automobile, to the extent that their total value does not exceed such amount as the Secretary determines to be reasonable; and

(B) the value of any burial space (subject to such limits as to size or value as the Secretary may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which, as determined in accordance with and subject to limitations prescribed by the Secretary, is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion;

(4) such resources of an individual who is blind or disabled and who has a plan for achieving self-support approved by the Secretary, as may be necessary for the fulfillment of such plan;

(5) in the case of Natives of Alaska, shares of stock held in a Regional or a Village Corporation, during the period of twenty years in which such stock is inalienable, as provided in section 7(h) and section 8(c) of

the Alaska Native Claims Settlement Act [43 USCS §§ 1606(h), 1607(c)];

(6) assistance referred to in section 1612(b)(11) [42 USCS § 1382a(b)(11)] for the 9-month period beginning on the date such funds are received (or for such longer period as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1612(b)(12) [42 USCS § 1382a(b)(12)]; and

(7) any amount received from the United States which is attributable to under payments of benefits due for one or more prior months, under this title [42 USCS §§ 1381 et seq.] or title II [42 USCS §§ 401 et seq.] to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title [42 USCS §§ 1381 et seq.] but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 6 months following the month in which such amount is received, and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount.

In determining the resources of an individual (or eligible spouse) an insurance policy shall be taken into account only to the extent of its cash surrender value; except that if the total face value of all life insurance policies on any person is $1,500 or less, no part of the value of any such policy shall be taken into account

(b) **Disposition of resources.** The Secretary shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(c) **Resources disposed of for less than fair market value.** (1) In determining the resources of an individual (and his eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a)) any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.

(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse

furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

(3) For purposes of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any.

(d) **Funds set aside for burial expenses.** (1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse if the inclusion of any portion of such amount or amounts would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a) [42 USCS § 1382(a)(1), (2)].

(2) The amount of $1,500, referred to in paragraph (1), with respect to an individual shall be reduced by an amount equal to (A) the total face value of all insurance policies on his life which are owned by him or his spouse and the cash surrender value of which has been excluded in determining the resources of such individual or of such individual and his spouse, and (B) the total of any amounts in an irrevocable trust (or other irrevocable arrangement) available to meet the burial and related expenses of such individual or his spouse.

(3) If the Secretary finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside, he shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) The Secretary may provide by regulations that whenever an amount set aside to meet burial and related expenses is excluded under paragraph (1) in determining the resources of an individual, any interest earned or accrued on such amount (and left to accumulate), and any appreciation in the value of prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

(Aug. 14, 1935, ch 531, Title XVI, Part A, § 1613, as added Oct. 30, 1972, P. L. 92-603, Title III, § 301, 86 Stat. 1470.; Oct. 20, 1976, P. L. 94-569, § 5, 90 Stat. 2700; Nov. 12, 1977, P. L. 95-171, § 9(a), 91 Stat. 1355; Dec. 28, 1980, P. L. 96-611, § 5(a), 94 Stat. 3567; Sept. 3, 1982, P. L. 97-248, Title I, Subtitle F, § 185(a), (b), 96 Stat. 406; July 18, 1984, P. L. 98-369, Division B, Title VI, Subtitle B, Part 1, § 2614, 98 Stat. 1132.)

§ 1382b. Resources

(a) **Exclusions from resources.** [Introductory matter unchanged]

(1) [Unchanged]

(2)(A) [Unchanged]

(B) the value of any burial space or agreement (including any interest accumulated thereon) representing the purchase of a burial space (subject to such limits as to size or value as the Secretary may by regulation prescribe) held for the purpose of providing a place for the burial of the individual, his spouse, or any other member of his immediate family;

(3) other property which is so essential to the means of self-support of such individual (and such spouse) as to warrant its exclusion, as determined in accordance with and subject to limitations prescribed by the Secretary, except that the Secretary shall not establish a limitation on property (including the tools of a tradesperson and the machinery and livestock of a farmer) that is used in a trade or business or by such individual as an employee;

(4), (5) [Unchanged]

(6) assistance referred to in section 1612(b)(11) [42 USCS § 1382a(b)(11)] for the 9-month period beginning on the date such funds are received (or for such longer period as the Secretary shall by regulations prescribe in cases where good cause is shown by the individual concerned for extending such period); and, for purposes of this paragraph, the term "assistance" includes interest thereon which is excluded from income under section 1612(b)(12) [42 USCS § 1382a(b)(12)];

(7) any amount received from the United States which is attributable to under payments of benefits due for one or more prior months, under this title [42 USCS §§ 1381 et seq.] or title II [42 USCS §§ 401 et seq.] to such individual (or spouse) or to any other person whose income is deemed to be included in such individual's (or spouse's) income for purposes of this title [42 USCS §§ 1381 et seq.] but the application of this paragraph in the case of any such individual (and eligible spouse if any), with respect to any amount so received from the United States, shall be limited to the first 6 months following the month in which such amount is received (or to the first 9 months following such month with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989),.and written notice of this limitation shall be given to the recipient concurrently with the payment of such amount;

(8) the value of assistance referred to in section 1612(b)(14) [42 USCS § 1382a(b)(14)], paid with respect to the dwelling unit occupied by such individual (or such individual and spouse);

(9) for the 9-month period beginning after the month in which received, any amount received by such individual (or such spouse) from a fund established by a State to aid victims of crime, to the extent that such individual (or such spouse) demonstrates that such amount was paid as compensation for expenses incurred or losses suffered as a result of a crime; and

(10) for the 9-month period beginning after the month in which received, relocation assistance provided by a State or local government to such individual (or such spouse), comparable to assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act [42 USCS § 4636].

[(11)](10) for the month of receipt and the following month, any refund of Federal income taxes made to such individual (or such spouse) by reason of section 32 of the Internal Revenue Code of 1986 [26 USCS § 32] (relating to earned income tax credit), and any payment made to such individual (or such spouse) by an employer under section 3507 of such Code [26 USCS § 3507] (relating to advance payment of earned income credit).

[Concluding matter unchanged]

(b) **Disposition of resources.** (1) The Secretary shall prescribe the period or periods of time within which, and the manner in which, various kinds of property must be disposed of in order not to be included in determining an individual's eligibility for benefits. Any portion of the individual's benefits paid for any such period shall be conditioned upon such disposal; and any benefits so paid shall (at the time of the disposal) be considered overpayments to the extent they would not have been paid had the disposal occurred at the beginning of the period for which such benefits were paid.

(2) Notwithstanding the provisions of paragraph (1), the Secretary shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Secretary, the owner's reasonable efforts to sell it have been unsuccessful.

(c) Notification of Medicaid policy restricting eligibility of institutionalized individuals for benefits based on disposal of resources for less than fair market value. (1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

(A) inform such individual of the provisions of section 1917(c) [42 USCS § 1396p(c)] providing for a period of ineligibility for benefits under title XIX for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of section 1917(c) [42 USCS § 1396p(c)] if such individual (or such spouse, if any) enters a medical institution or nursing facility.

(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.

(d) **Funds set aside for burial expenses.** (1) In determining the resources of an individual, there shall be excluded an amount, not in excess of $1,500 each with respect to such individual and his spouse (if any), that is separately identifiable and has been set aside to meet the burial and related expenses of such individual or spouse.

(2) [Unchanged]

(3) If the Secretary finds that any part of the amount excluded under paragraph (1) was used for purposes other than those for which it was set aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a) [42 USCS § 1382(a)(1) or (2)], he shall reduce any future benefits payable to the eligible individual (or to such individual and his spouse) by an amount equal to such part.

(4) [Unchanged]

(As amended Dec. 22, 1987, P. L. 100-203, Title IX, Subtitle B, Part 1, §§ 9103(a), 9104(a), 9105(a),

TITLE XIX. GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

CROSS REFERENCES

This Title is referred to in 7 USCS §§ 2026, 3178; 8 USCS § 1522; 12 USCS §§ 1715w, 1715z-7; 25 USCS § 1622; 38 USCS §§ 622, 4108; 42 USCS §§ 242b, 254a-1, 254b, 254c, 254e, 254h, 254n, 300e, 300e-6, 300m-6, 300z-5, 602, 603, 606, 614, 632a, 671, 671, 673, 705, 709, 1301, 1306, 1308, 1309, 1310, 1315, 1316, 1318, 1320a-1, 1320a-2, 1320a-3, 1320a-5, 1320a-7, 1320a-7a, 1320a-8, 1320b-2, 1320b-3, 1320b-4, 1320b-5, 1320c-2, 1320c-10, 1382, 1382g, 1382h, 1382i, 1383c, 1395b-1, 1395v, 1395x, 1395y, 1395z, 1395cc, 1395mm, 1395H, 1395vv, 1395ww, 1997, 3013, 3026, 3035b, 8624

§ 1396. Appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title [42 USCS §§ 1396 et seq.]. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.

(Aug. 14, 1935, ch 531, Title XIX, § 1901, as added July 30, 1965, P. L. 89-97, Title I, Part 2, § 121(a), 79 Stat. 343; Dec. 31, 1973, P. L. 93-233, § 13(a)(1), 87 Stat. 960; July 18, 1984, P. L. 98-369, Division B, Title VI, Subtitle D, § 2663(j)(3)(C), 98 Stat. 1171.)

§ 1396a. State plans for medical assistance

(a) **Contents.** A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1903 [42 USCS § 1396b] are authorized by this title [42 USCS §§ 1396 et seq.]; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency, and (C) that each State or local officer or employee who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer or employee, and each partner of such an officer or employee shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of title 18, United States Code [18 USCS §§ 207, 208];

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to

administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under title I or XVI [42 USCS §§ 301 et seq., 1381 et seq.] (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.], or by the agency or agencies administering the supplemental security income program established under title XVI [42 USCS §§ 1381 et seq.] or the State Plan approved under part A of title IV [42 USCS §§ 601 et seq.] if the State is not eligible to participate in the State plan program established under title XVI; [42 USCS §§ 1381 et seq.]

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1864(a) [42 USCS § 1395aa(a)]), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions, and

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs (11) and (12) of section 1861(s) [42 USCS § 1395x(e)(9), (s)(11), (12)], or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G) [42 USCS § 1395x(aa)(2)(G)];

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) [42 USCS § 1396d(a)(1)–(5), (17)], to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq. 670 et seq.] (including individuals eligible under this title [42 USCS §§ 1396 et seq.] by reason of section 402(a)(37) or 406(h) [42 USCS § 602(a)(37), 606(h)], or considered by the State to be receiving such aid as authorized under section 414(g) [42 USCS § 614(g)]),

(II) with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS § 1381 et seq.], or

(III) who are qualified pregnant women or children as defined in section 1905(n) [42 USCS § 1396d(n)];

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) [42 USCS § 1396d(a)] (or, in the case of individuals described in section 1905(a)(i) [42 USCS § 1396d(a)(1)], to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be).

(II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,

(III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,

(IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.], or a State supplementary payment;[,]

(V) who are in a medical institution, who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C) [42 USCS § 1396b(f)(4)(C)], or

(VI) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in section 1915(c) [42 USCS § 1396n(c)] they would require the level of care provided in a hospital, skilled nursing facility or

intermediate care facility the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1915(c) [42 USCS § 1396n(c)];

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) [42 USCS § 1396d(a)] who are not described in subparagraph (A), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii) the plan must make available medical assistance—

(I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) [42 USCS § 1396d(1)–(5), (17)] or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) [42 USCS § 1396d(a)(4), (14), (16)] to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII [42 USCS §§ 1395j et seq.] to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 [42 USCS § 1395v] or by reason of the payment of premiums under such title [42 USCS §§ 1395 et seq.] by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII [42 USCS §§ 1395j et seq.] for individuals eligible for benefits under such part [42 USCS §§ 1395j et seq.], shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individials described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A)[,] and (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) [42 USCS § 1396*o*(a)(2), (b)(2)] shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption;

§ 1396a. State plans for medical assistance [Caution: See Other provisions notes for application of amendments]

(a) Contents. [Introductory matter unchanged]

(10) [Introductory matter unchanged]

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a) [42 USCS § 1396d(a)(1)-(5), (17), (21)], to—

(i) [Introductory matter unchanged]

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq. or 670 et seq.] (including individuals eligible under this title [42 USCS §§ 1396 et seq.] by reason of section 402(a)(37), 406(h), or 473(b) [42 USCS § 602(a)(37), 606(h), or 673(b)], or considered by the State to be receiving such aid as authorized under section 482(e)(6) [42 USCS § 682(e)(6)]),

(II) with respect to whom supplemental security income benefits are being paid under title XVI [42 USCS § 1381 et seq.] or who are qualified severely impaired individuals (as defined in section 1905(q) [42 USCS § 1396d(q)]),

(III) who are qualified pregnant women or children as defined in section 1905(n) [42 USCS § 1396d(n)],

(IV) who are described in subparagraph (A) or (B) of subsection *(l)*(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection *(l)*(2)(A) for such a family; [,] or

(V) who are qualified family members as defined in section 1905(m)(1) [42 USCS § 1396d(m)(1)]

(VI) who are described in subparagraph (C) of subsection *(l)*(1) and whose family income does not exceed the income level the State is required to establish under subsection *(l)*(2)(B) for such a family, or

(VII) who are described in subparagraph (D) of subsection (*l*)(1) and whose family income does not exceed the income level the State is required to establish under subsection (*l*)(2)(C) for such a family;

(ii) [Introductory matter unchanged]

(I)-(IV) [Unchanged]

(V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1903(f)(4)(C) [42 USCS § 1396b(f)(4)(C)],

(VI) who would be eligible under the State plan under this title [42 USCS §§ 1396 et seq.] if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1915 [42 USCS § 1396n(c), (d), or (e)] they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under section 1915(c) [42 USCS § 1396n(c)],

(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905*(o)* [42 USCS § 1396d*(o)*];

(VIII) who is a child described in section 1905(a)(i) [42 USCS § 1396d(a)(i)]—

(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV [42 USCS §§ 671 et seq.]) between the State and an adoptive parent or parents,

(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of title IV [42 USCS §§ 671 et seq.] were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of title IV [42 USCS §§ 671 et seq.];

(IX) who are described in subsection *(l)*(1) and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII);

(X) who are described in subsection (m)(1); or

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under title XVI [42 USCS §§ 1381 et seq.]), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Secretary under section 1616 or 1634 [42 USCS § 1382e or § 1383c];

(B) [Unchanged]

(C) that if medical assistance is included for any group of individuals described in section 1905(a) [42 USCS § 1396d(a)] who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

(ii), (iii) [Unchanged]

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) [42 USCS § 1396d(1)-(5), (17)] or the care and services listed in any 7 of the paragraphs numbered (1) through (20) of such section;

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services; and

(E)(i) but, for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3) [42 USCS § 1396d(p)(3)]) for qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)];

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) [42 USCS § 1396d(p)(3)(A)(i)] for qualified disabled and working individuals described in section 1905(s) [42 USCS § 1396d(s)];

(iii) for making medical assistance available for medicare cost sharing described in section 1905(p)(3)(A)(ii) [42 USCS § 1396d(p)(3)(A)(ii)] subject to section 1905(p)(4) [42 USCS § 1396d(p)(4)], for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) [42 USCS § 1396d(p)(2)] but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and

(F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2)) for qualified COBRA continuation beneficiaries described in section 1902(u)(1) [subsec. (u)(1) of this section];

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) [42 USCS § 1396d(a)(4), (14), (16)] to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of

title XVIII [42 USCS §§ 1395j et seq.] to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 [42 USCS § 1395v] or by reason of the payment of premiums under such title [42 USCS §§ 1395 et seq.] by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII [42 USCS §§ 1395j et seq.] for individuals eligible for benefits under such part [42 USCS §§ 1395j et seq.], shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) [42 USCS § 1396o(a)(2), (b)(2)] shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) [42 USCS § 1396d(o)] to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII [42 USCS §§ 1395 et seq.], and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) [42 USCS § 1396d(p)(1)] shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3) [42 USCS § 1396d(p)(3)]), subject to the provisions of subsection (n) and section 1916(b) [42 USCS § 1396o(b)], (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A) [42 USCS § 1396r-4], as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals; (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 [42 USCS § 1396e] shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals[;], and [(XII)](XI) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2));

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], and with respect to whom supplemental security income benefits are not being paid under title XVI [42 USCS §§ 1381 et seq.], based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title [42 USCS §§ 1396 et seq.], (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], or to have paid with respect to him supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.]) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under 21 or

(with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 [42 USCS § 1382c] (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(17) except as provided in subsections (l)(3), and (m)(4)[,] include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], and with respect to whom supplemental security income benefits are not being paid under title XVI [42 USCS §§ 1381 et seq.], based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title [42 USCS §§ 1396 et seq.], (B) provide

for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., 601 et seq.], or to have paid with respect to him supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.]) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under 21 or (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 [42 USCS § 1382c] (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1903(f)(2)(B) [42 USCS § 1396b(f)(2)(B)], or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

(ii) who is or are determined to be eligible for medical assistance under the State plan.

(2) The minimum monthly personal needs allowance described in this paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

(r) **Disregarding payments for certain medical expenses by institutionalized individuals.** (1) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) [subsec. (a)(17) of this section and 42 USCS § 1396r-5(d)(1)(D)] and for purposes of a waiver under section 1915 [42 USCS § 1396n], with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

(i) medicare and other health insurance premiums, deductibles, or coinsurance, and

(ii) necessary medical or remedial care recognized under State law but not covered under the State plan under this title [42 USCS §§ 1396 et seq.], subject to reasonable limits the State may establish on the amount of these expenses.

(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or (f) or under section 1905(p) [1396d(p)] may be less restrictive, and shall be no more restrictive, than the methodology—

(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI [42 USCS §§ 1381 et seq.], or

(ii) in the case of other groups, under the State plan most closely categorically related.

(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.

(s) **Adjustment in payment for hospital services furnished to low-income children under the age of 1 years.** In order to meet the requirements of subsection (a)(55), the State plan must provide that payment to hospitals under the plan for inpatient hospital services furnished to infants who have not attained the age of 1 year, and to children who have not attained the age of 6 years and who receive such services in a disproportionate share hospital described in section 1923(b)(1) [42 USCS § 1396r-4(b)(1)], shall—

(1) if made on a prospective basis (whether per diem, per case, or otherwise) provide for an outlier adjustment in payment amounts for medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay,

(2) not be limited by the imposition of day limits with respect to the delivery of such services to such individuals, and

(3) not be limited by the imposition of dollar limits (other than such limits resulting from prospective payments as adjusted pursuant to paragraph (1)) with respect to the delivery of such services to any such individual who has not attained their first birthday (or in the case of such an individual who is an inpatient on his first birthday until such individual is discharged).

(t) **State tax contribution.** Except as provided in section 1903(i) [42 USCS § 1396b(i)], nothing in this title [42 USCS §§ 1396 et seq.] (including sections 1903(a) and 1905(a) [42 USCS §§ 1936b(a), 1396d(a)]) shall be construed as authorizing the Secretary to deny or limit payments to a State for expenditures, for medical assistance for items or services, attributable to taxes (whether or not of general applicability) imposed with respect to the provision of such items or services.

(u) **Federal assistance for payments for COBRA continuation coverage.** (1) Individuals described in this paragraph are individuals—

(A) who are entitled to elect COBRA continuation coverage (as defined in paragraph (3)),

(B) whose income (as determined under section 1612 [42 USCS § 1383] for purposes of the supplemental security income program) does not exceed 100 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 USCS § 9902 (2)]) applicable to a family of the size involved,

(C) whose resources (as determined under section 1613 [42 USCS § 1384] for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program, and

(D) with respect to whose enrollment for COBRA continuation coverage the State has determined that the savings in expenditures under this title [42 USCS §§ 1396 et seq.] resulting from such enrollment is likely to exceed the amount of payments for COBRA premiums made.

(2) For purposes of subsection (a)(10)(F) and this subsection, the term "COBRA premiums" means the applicable premium imposed with respect to COBRA continuation coverage.

ARTICLE 3

TESTS OF NEWBORN INFANTS

26-17-21. PKU tests of newborn infants — Board of Health to establish rules and regulations.

The Board of Health shall establish rules and regulations requiring each newborn infant to be tested for the presence of phenylketonuria (PKU) and other metabolic diseases which may result in mental retardation or brain damage and for which a preventive measure or treatment is available and for which a laboratory diagnostic test method has been found reliable.

History: L. 1965, ch. 49, § 1; 1967, ch. 174, § 36.

Cross-References. — Fees for and restriction on testing, § 26-10-6.

26-17-22. Repealed.

Repeals. — Section 26-17-22 (L. 1965, ch. 49, § 2), relating to the penalty for violations of regulations relating to PKU tests, was repealed by Laws 1967, ch. 174, § 162.

CHAPTER 18

MEDICAL ASSISTANCE ACT

Sunset Act. — See Section 63-55-7 for the termination date of the Medical Assistance Act.

Section		Section	
26-18-1.	Short title.		modifying department rules — Compliance with Social Security Act.
26-18-2.	Definitions.	26-18-6.	Federal aid — Authority of executive director.
26-18-2.1.	Division — Creation.	26-18-7.	Medical vendor rates.
26-18-2.2.	Director — Appointment — Responsibilities.	26-18-8.	Enforcement of public assistance statutes — Contract with Office of Recovery Services.
26-18-2.3.	Division responsibilities — Emphasis — Periodic assessment.	26-18-9.	Prohibited acts of state or local employees of Medicaid program — Violation a misdemeanor.
26-18-3.	Administration of Medicaid program by department.	26-18-10.	Utah Medical Assistance Program — Policies and standards.
26-18-3.5.	Copayments by health service recipients, spouses, and parents.	26-18-11.	Rural hospitals.
26-18-4.	Department standards for eligibility under Medicaid — Funds for abortions.		
26-18-5.	Contracts for provision of medical services — Federal provisions		

26-18-1. Short title.

This chapter shall be known and may be cited as the "Medical Assistance Act."

History: C. 1953, 26-18-1, enacted by L. 1981, ch. 126, § 17.

Repeals and Reenactments. — Laws 1981, ch. 126, § 1 repealed former §§ 26-18-1 to 26-18-4 (L. 1963, ch. 38, §§ 1 to 4; 1969, ch. 197, §§ 64, 65; 1971, ch. 53, § 1), relating to use of confidential information in research. Present §§ 26-18-1 to 26-18-10 were enacted

by § 17 of the act. For present provisions relating to confidential information, see Chapter 25 of this title.

26-18-2. Definitions.

As used in this chapter:

(1) "Applicant" means any person who requests assistance under the medical programs of the state.

(2) "Division" means the Division of Health Care Financing within the department, established under Section 26-18-2.1.

(3) "Client" means a person who the department has determined to be eligible for assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

(4) "Medicaid program" means the state program for medical assistance for persons who are eligible under the state plan adopted pursuant to Title XIX of the federal Social Security Act.

(5) "Medical or hospital assistance" means services furnished or payments made to or on behalf of recipients of medical or hospital assistance under state medical programs.

(6) "Recipient" means a person who has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10.

History: C. 1953, 26-18-2, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 1.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, added present Subsections (2) and (3), designated former Subsections (2) and (3) as Subsections (5) and (6), and, in Subsection (6), substituted "has received medical or hospital assistance under the Medicaid program or the Utah Medical Assistance Program established under Section 26-18-10" for "the department has determined to be eligible for medical or hospital assistance under the medical programs of the state."

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

26-18-2.1. Division — Creation.

There is created, within the department, the Division of Health Care Financing which shall be responsible for implementing, organizing, and maintaining the Medicaid program and the Utah Medical Assistance Program established in Section 26-18-10, in accordance with the provisions of this chapter and applicable federal law.

History: C. 1953, 26-18-2.1, enacted by L. 1988, ch. 21, § 2.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective on July 1, 1988.

26-18-2.2. Director — Appointment — Responsibilities.

The director of the division shall be appointed by the executive director of the department. The director of the division may employ other employees as necessary to implement the provisions of this chapter, and shall:

(1) administer the responsibilities of the division as set forth in this chapter;

(2) prepare and administer the division's budget; and

(3) establish and maintain a state plan for the Medicaid program in compliance with federal law and regulations.

History: C. 1953, 26-18-2.2, enacted by L. 1988, ch. 21, § 3.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective on July 1, 1988.

26-18-2.3. Division responsibilities — Emphasis — Periodic assessment.

(1) In accordance with the requirements of Title XIX of the Social Security Act and applicable federal regulations, the division is responsible for the effective and impartial administration of this chapter in an efficient, economical manner. The division shall establish, on a statewide basis, a program to safeguard against unnecessary or inappropriate use of Medicaid services, excessive payments, and unnecessary or inappropriate hospital admissions or lengths of stay. The division shall deny any provider claim for services that fail to meet criteria established by the division concerning medical necessity appropriateness. The division shall place its emphasis on high quality care to recipients in the most economical and cost-effective manner possible, with regard to both publicly and privately provided services.

(2) The division shall implement and utilize cost-containment methods, where possible, which may include, but are not limited to:

(a) prepayment and postpayment review systems to determine if utilization is reasonable and necessary;

(b) preadmission certification of nonemergency admissions;

(c) mandatory outpatient, rather than inpatient, surgery in appropriate cases;

(d) second surgical opinions;

(e) procedures for encouraging the use of outpatient services;

(f) coordination of benefits; and

(g) review and exclusion of providers who are not cost effective or who have abused the Medicaid program, in accordance with the procedures and provisions of federal law and regulation.

(3) The director of the division shall periodically assess the cost effectiveness and health implications of the existing Medicaid program, and consider alternative approaches to the provision of covered health and medical services through the Medicaid program, in order to reduce unnecessary or unreasonable utilization.

History: C. 1953, 26-18-2.3, enacted by L. 1988, ch. 21, § 4.

Effective Dates. — Laws 1988, ch. 21, § 10 makes the act effective July 1, 1988.

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

26-18-3. Administration of Medicaid program by department.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

(3) The department may, in its discretion, contract with the Department of Social Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws to the extent permitted by law and quality control services.

(4) The department may provide by rule for disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures of the program, provided that sanctions imposed administratively shall not extend beyond termination from the program or recovery of claim reimbursements incorrectly paid.

History: C. 1953, 26-18-3, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 5.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in Subsection (2) substituted "this chapter, the requirements of Title XIX, and applicable federal regulations" for "the requirements of Title XIX and with regulations adopted pursuant thereto by the federal agency" and made various minor phraseology and stylistic changes.

Social Security Act. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq.

COLLATERAL REFERENCES

C.J.S. — 81 C.J.S. Social Security and Public Welfare § 126

Key Numbers. — Social Security ⇐ 241.

26-18-3.5. Copayments by health service recipients, spouses, and parents.

The department shall selectively provide for enrollment fees, premiums, deductions, cost sharing or other similar charges to be paid by recipients, their spouses, and parents, within the limitations of federal law and regulation.

History: C. 1953, 26-18-3.5, enacted by L. 1983, ch. 135, § 1.

COLLATERAL REFERENCES

Utah Law Review. — Utah Legislative Survey — 1983, 1984 Utah L. Rev. 115, 169.

26-18-4. Department standards for eligibility under Medicaid — Funds for abortions.

(1) The department may develop standards and administer policies relating to eligibility under the Medicaid program. An applicant receiving Medicaid assistance may be limited to particular types of care or services or to payment of part or all costs of care determined to be medically necessary.

(2) The department shall not provide any funds for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is to perform an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(3) Any employee of the department who authorizes payment for an abortion contrary to the provisions of this section is guilty of a class B misdemeanor and subject to forfeiture of office.

(4) Any person or organization that, under the guise of other medical treatment, provides an abortion under auspices of the Medicaid program is guilty of a third degree felony and subject to forfeiture of license to practice medicine or authority to provide medical services and treatment.

History: C. 1953, 26-18-4, enacted by L. 1981, ch. 126, § 17; 1987, ch. 181, § 2.

Amendment Notes. — The 1987 amendment deleted former Subsection (1), relating to the responsibility of counties, redesignated the subsequent subsections accordingly and made minor changes in phraseology throughout the section.

Cross-References. — Penalties for misdemeanors, §§ 76-3-204, 76-3-301.

Sentencing for felonies, §§ 76-3-201, 76-3-203, 76-3-301.

26-18-5. Contracts for provision of medical services — Federal provisions modifying department rules — Compliance with Social Security Act.

(1) The department may contract with other public or private agencies to purchase or provide medical services in connection with the programs of the division. Where these programs are used by other state agencies, contracts shall provide that other state agencies transfer the state matching funds to the department in amounts sufficient to satisfy needs of the specified program.

(2) All contracts for the provision or purchase of medical services shall be established on the basis of the state's fiscal year and shall remain uniform during the fiscal year insofar as possible. Contract terms shall include provisions for maintenance, administration, and service costs.

(3) If a federal legislative or executive provision requires modifications or revisions in an eligibility factor established under this chapter as a condition for participation in medical assistance, the department may modify or change its rules as necessary to qualify for participation; providing, the provisions of this section shall not apply to department rules governing abortion.

(4) The department shall comply with all pertinent requirements of the Social Security Act and all orders, rules, and regulations adopted thereunder when required as a condition of participation in benefits under the Social Security Act.

History: C. 1953, 26-18-5, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 6.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in the first sentence of Subsection (1) substituted "division" for "department" and in Subsection (3) substituted "its rules as necessary" for "department rules necessary."

Social Security Act. — The federal Social Security Act is codified as 42 U.S.C. § 301 et seq.

26-18-6. Federal aid — Authority of executive director.

The executive director, with the approval of the governor, may bind the state to any executive or legislative provisions promulgated or enacted by the federal government which invite the state to participate in the distribution, disbursement or administration of any fund or service advanced, offered or contributed in whole or in part by the federal government for purposes consistent with the powers and duties of the department. Such funds shall be used as provided in this chapter and be administered by the department for purposes related to medical assistance programs.

History: C. 1953, 26-18-6, enacted by L. 1981, ch. 126, § 17.

26-18-7. Medical vendor rates.

Medical vendor payments made to providers of services for and in behalf of recipient households shall be based upon predetermined rates from standards developed by the division in cooperation with providers of services for each type of service purchased by the division. As far as possible, the rates paid for services shall be established in advance of the fiscal year for which funds are to be requested.

History: C. 1953, 26-18-7, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 7.

Amendment Notes. — The 1988 amendment, effective July 1, 1988, in the first sentence twice substituted "division" for "department."

26-18-8. Enforcement of public assistance statutes — Contract with Office of Recovery Services.

(1) The department shall enforce or contract for the enforcement of the provisions of Sections 62A-9-121, 62A-9-129, 62A-9-131 through 62A-9-133, and 62A-9-135 insofar as these sections pertain to benefits conferred or administered by the division under this chapter.

(2) The department may contract for services covered in Part 1, Chapter 11, Title 62A insofar as that chapter pertains to benefits conferred or administered by the division under this chapter.

History: C. 1953, 26-18-8, enacted by L. 1981, ch. 126, § 17; 1988, ch. 1, § 2; 1988, ch. 21, § 8.

Amendment Notes. — The 1988 amendment by Chapter 1, effective January 19, 1988, substituted the present statutory references for "Sections 55-15a-24, and 55-15a-29 through 55-15a-33" in Subsection (1) and "Chapter 15c of Title 55" in Subsection (2).

The 1988 amendment by Chapter 21, effective July 1, 1988, substituted "division" for "department" throughout the section.

This section has been reconciled by the Office of Legislative Research and General Counsel.

26-18-9. Prohibited acts of state or local employees of Medicaid program — Violation a misdemeanor.

Each state or local employee responsible for the expenditure of funds under the state Medicaid program, each individual who formerly was such an officer or employee, and each partner of such an officer or employee is prohibited for a period of one year after termination of such responsibility from committing any act, the commission of which by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by Section 207 or Section 208 of Title 18, United States Code. Violation of this section is a class A misdemeanor.

History: C. 1953, 26-18-9, enacted by L. 1981, ch. 126, § 17.

Compiler's Notes. — 18 U.S.C. §§ 207 and 208 deal respectively with participation by former federal officers or employees in matters involving the government and with involvement by federal officers or employees in their official capacity in matters in which they have a personal financial interest.

Cross-References. — Penalty for misdemeanors, §§ 76-3-204, 76-3-301.

26-18-10. Utah Medical Assistance Program — Policies and standards.

(1) The division shall develop a medical assistance program, which shall be known as the Utah Medical Assistance Program, for low income persons who are not eligible under the state plan for Medicaid under Title XIX of the Social Security Act or Medicare under Title XVIII of that act.

(2) Persons in the custody of prisons, jails, halfway houses, and other nonmedical government institutions are not eligible for services provided under this section.

(3) The department shall develop standards and administer policies relating to eligibility requirements for participation in the program, and for payment of medical claims for eligible persons.

(4) The program shall be a payor of last resort. Before assistance is rendered the division shall investigate the availability of the resources of the spouse, father, mother, and adult children of the person making application.

(5) The department shall determine what medically necessary care or services are covered under the program, including duration of care, and method of payment, which may be partial or in full.

(6) The department shall not provide public assistance for medical, hospital, or other medical expenditures or medical services to otherwise eligible persons where the purpose of the assistance is for the performance of an abortion, unless the life of the mother would be endangered if an abortion were not performed.

(7) The department may establish rules to carry out the provisions of this section.

History: C. 1953, 26-18-10, enacted by L. 1982, ch. 26, § 1; 1985, ch. 165, § 38; 1987, ch. 181, § 3; 1988, ch. 21, § 9.

Repeals and Reenactments. — Laws 1982, ch. 26, § 1 repealed former § 26-18-10 (C. 1953, 26-18-10, enacted by L. 1981, ch. 126, § 17), relating to duties of the department, and enacted present § 26-18-10.

Amendment Notes. — The 1985 amendment substituted "equivalent of .00005" for "equivalent of 1/4 mill" in two places in Subsection (6).

The 1987 amendment, *effective July 1, 1987*, in Subsection (1), substituted "Medicare under Title XVIII of that act" for "Medicare under Title XVII of said act," deleted former Subsection (6), which provided for relief of the obligation of counties to provide medical care to the indigent, and made minor changes in phraseology and punctuation throughout the section.

The 1988 amendment, effective July 1, 1988, substituted "division" for "department" in *Subsections (1) and (4) and in Subsection (1) inserted* "which shall be known as the Utah Medical Assistance Program."

Social Security Act. — Title XIX of the federal Social Security Act, cited in Subsection (1), appears as 42 U.S.C. §§ 1396 to 1396s. Title XVIII of the act appears as 42 U.S.C. §§ 1395 to 1395ccc.

COLLATERAL REFERENCES

Journal of Contemporary Law. — Utah's Medicaid Program: A Senior's Eligibility Guide for Private Practitioners, 14 J. Contemp. L. 1 (1988).

26-18-11. Rural hospitals.

(1) For purposes of this section "rural hospital" means a hospital located outside of a standard metropolitan statistical area, as designated by the United States Bureau of the Census.

(2) For purposes of the Medicaid program and the Utah Medical Assistance Program, the Division of Health Care Financing shall not discriminate among *rural hospitals on the basis of size.*

History: C. 1953, 26-18-11, **enacted by L. 1988, ch. 12, § 1.**

Effective Dates. — Laws 1988, ch. 12, § 2 makes the act effective on July 1, 1988.

CHAPTER 19
MEDICAL BENEFITS RECOVERY ACT

Section
26-19-1. Short title.
26-19-2. Definitions.
26-19-3. Program established by department — Promulgation of rules.
26-19-4. Repealed.
26-19-5. Recovery of medical assistance from third party liable for payment — Notice — Action — Compromise or waiver — Recipient's right to action protected — Limit on payment for liability.
26-19-6. Action by department — Notice to recipient.
26-19-7. Action or claim by recipient — Consent of department required — Department's right to intervene — Department's interests protected — Attorney's fees and costs.
26-19-8. Statute of limitations — Survival of right of action — Insurance policy not to limit time allowed for recovery.
26-19-9 to 26-19-12. Repealed.
26-19-13. Recovery of medical assistance payments from recipient — Lien against estate — Recovery of incorrectly paid amounts.
26-19-14. Insurance policies not to deny or reduce benefits of persons eligible for state medical assistance — Exemptions.
26-19-15. Attorney general or county attorney to represent department.
26-19-16. Department's right to attorney's fees and costs.
26-19-17. Application of provisions contrary to federal law prohibited.
26-19-18. Release of medical billing information by provider restricted — Liability for violation.

CHAPTER 17

MENTAL HEALTH

(Repealed by Laws 1967, ch. 174, § 162; 1969, ch. 197, § 187; 1971, ch. 172, § 27; 1988, ch. 1, § 407; 1989, ch. 22, § 51.)

26-17-1 to 26-17-22. Repealed.

Repeals. — Laws 1989, ch. 22, § 51 repeals this chapter, as enacted by Laws 1961, ch. 54 and by Laws 1987, ch. 180, § 1; 1987, ch. 179, § 8; and 1967, ch. 174, § 153 and as amended by Laws 1969, ch. 197, §§ 60 and 63; 1979, ch. 233, § 1; 1987, ch. 141, § 1; 1987, ch. 179, §§ 1, 3 to 7, and 9; 1967, ch. 174, §§ 36 and 147; 1980, ch. 30, § 1; 1979, ch. 97, § 3; and 1981, ch. 120, § 3, effective April 24, 1989. For present comparable provisions, see Chapter 12 of Title 62A.

CHAPTER 18

MEDICAL ASSISTANCE ACT

Sunset Act. — Section 63-55-226 provides that the Medical Assistance Act is repealed July 1, 1994.

Section

26-18-3. Administration of Medicaid program by department — Disciplinary measures and sanctions — Funds collected.

26-18-2.1. Division — Creation.

Sunset Act. — Section 63-55-226 provides that the Division of Health Care Financing is repealed July 1, 1994.

26-18-3. Administration of Medicaid program by department — Disciplinary measures and sanctions — Funds collected.

(1) The department shall be the single state agency responsible for the administration of the Medicaid program in connection with the United States Department of Health and Human Services pursuant to Title XIX of the Social Security Act.

(2) The department shall develop implementing policy in conformity with this chapter, the requirements of Title XIX, and applicable federal regulations.

(3) The department may, in its discretion, contract with the Department of Human Services or other qualified agencies for services in connection with the administration of the Medicaid program, including but not limited to the determination of the eligibility of individuals for the program, recovery of overpayments, and enforcement of fraud and abuse laws to the extent permitted by law and quality control services.

(4) The department shall provide, by rule, disciplinary measures and sanctions for Medicaid providers who fail to comply with the rules and procedures

of the program, provided that sanctions imposed administratively may not extend beyond:

(a) termination from the program;

(b) recovery of claim reimbursements incorrectly paid; and

(c) those specified in Section 1919 of Title XIX of the federal Social Security Act.

(5) Funds collected as a result of a sanction imposed under Section 1919 of Title XIX of the federal Social Security Act shall be deposited in the General Fund as nonlapsing dedicated credits to be used by the division in accordance with the requirements of that section.

History: C. 1953, 26-18-3, enacted by L. 1981, ch. 126, § 17; 1988, ch. 21, § 5; 1989, ch. 165, § 1; 1990, ch. 183, § 9.

Amendment Notes. — The 1989 amendment, effective April 24, 1989, added the (a) and (b) designations in Subsection (4); substituted "shall provide, by rule" for "may provide by rule for" and "may not extend" for "shall not extend" in the introductory language of Subsection (4); deleted "or" from the end of Subsection (4)(a); added "and" to the end of Subsection (4)(b); added Subsection (4)(c); made punctuation changes throughout Subsection (4); and added Subsection (5).

The 1990 amendment, effective April 23, 1990, substituted "Human" for "Social" in Subsection (3).

Federal Law. — Title XIX of the federal Social Security Act is compiled as 42 U.S.C. § 1396 et seq. Section 1919 of Title XIX is 42 U.S.C. § 1396r.

CHAPTER 19

MEDICAL BENEFITS RECOVERY ACT

Section	
26-19-2.	Definitions
26-19-5.	Recovery of medical assistance from third party liable for payment — Lien — Notice — Action — Compromise or waiver — Recipient's right to action protected.
26-19-7.	Action or claim by recipient — Consent of department required — Department's right to intervene — Department's interests protected — Attorney's fees and costs.
26-19-18	Release of medical billing information by provider restricted — Exception — Liability for violation.

26-19-2. Definitions.

As used in this chapter:

(1) "Medical assistance" means any funds expended by the state under Chapter 18, Title 26, and under Titles XVIII and XIX of the Social Security Act.

(2) "Property" includes the homestead and all other property, personal or real, in which the recipient has a legal interest.

(3) "Provider" means a person or entity receiving compensation from any public medical assistance program for goods or services provided to a recipient.

(4) "Recipient" means a person who has applied for or received medical assistance from the state; his guardian, conservator, or other personal representative, if he is a minor or incapacitated person; and his estate and survivors if he is deceased.

(5) "Third party" means:

(f) the persons taking the agency action were illegally constituted as a decision-making body or were subject to disqualification;

(g) the agency action is based upon a determination of fact, made or implied by the agency, that is not supported by substantial evidence when viewed in light of the whole record before the court;

(h) the agency action is:

(i) an abuse of the discretion delegated to the agency by statute;

(ii) contrary to a rule of the agency;

(iii) contrary to the agency's prior practice, unless the agency justifies the inconsistency by giving facts and reasons that demonstrate a fair and rational basis for the inconsistency; or

(iv) otherwise arbitrary or capricious.

History: C. 1953, 63-46b-16, enacted by L. 1987, ch. 161, § 272; 1988, ch. 72, § 26.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, substituted "As provided by statute, the Supreme Court or the Court of Appeals" for "The Supreme Court or other appellate court designated by statute" in Subsection (1); inserted "with the appropriate appellate court" in Subsection (2)(a); and substituted "appellate rules of the appropriate appellate court" for "Utah Rules of Appellate Procedure" in Subsections (2)(a) and (2)(b).

Effective Dates. — Laws 1987, ch. 161, § 315 makes the act effective on January 1, 1988.

NOTES TO DECISIONS

Function of district court.

Subsection (1) provides that all final agency decisions through formal adjudicative proceedings will be reviewed by the Utah Supreme Court or Court of Appeals. Therefore, the district court will no longer function as intermediate appellate court except to review informal adjudicative proceedings de novo pursuant to § 63-46b-15(1)(a). In re Topik, 761 P.2d 32 (Utah Ct. App. 1988).

63-46b-17. Judicial review — Type of relief.

(1) (a) In either the review of informal adjudicative proceedings by the district court or the review of formal adjudicative proceedings by an appellate court, the court may award damages or compensation only to the extent expressly authorized by statute.

(b) In granting relief, the court may:

(i) order agency action required by law;

(ii) order the agency to exercise its discretion as required by law;

(iii) set aside or modify agency action;

(iv) enjoin or stay the effective date of agency action; or

(v) remand the matter to the agency for further proceedings.

(2) Decisions on petitions for judicial review of final agency action are reviewable by a higher court, if authorized by statute.

History: C. 1953, 63-46b-17, enacted by L. 1987, ch. 161, § 273.

Effective Dates. — Laws 1987, ch. 161, § 315 makes the act effective on January 1, 1988.

(b) The Utah Rules of Evidence apply in judicial proceedings under this section.

History: C. 1953, 63-46b-15, enacted by L. 1987, ch. 161, § 271; 1988, ch. 72, § 25.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, deleted "except that final agency action from informal adjudicative proceedings based on a record shall be reviewed by the district courts on the record according to the standards of Subsection 63-46b-16(4)" at the end in Subsection (1)(a) and made minor stylistic changes.

Effective Dates. — Laws 1987, ch. 161, § 315 makes the act effective on January 1, 1988.

NOTES TO DECISIONS

Function of district court.

Section 63-46b-16(1) provides that all final agency decisions through formal adjudicative proceedings will be reviewed by the Utah Supreme Court or Court of Appeals. Therefore, the district court will no longer function as intermediate appellate court except to review informal adjudicative proceedings de novo pursuant to Subsection (1)(a) of this section. In Topik, 761 P.2d 32 (Utah Ct. App. 1988).

63-46b-16. Judicial review — Formal adjudicative proceedings.

(1) As provided by statute, the Supreme Court or the Court of Appeals has jurisdiction to review all final agency action resulting from formal adjudicative proceedings.

(2) (a) To seek judicial review of final agency action resulting from formal adjudicative proceedings, the petitioner shall file a petition for review of agency action with the appropriate appellate court in the form required by the appellate rules of the appropriate appellate court.

(b) The appellate rules of the appropriate appellate court shall govern all additional filings and proceedings in the appellate court.

(3) The contents, transmittal, and filing of the agency's record for judicial review of formal adjudicative proceedings are governed by the Utah Rules of Appellate Procedure, except that:

(a) all parties to the review proceedings may stipulate to shorten, summarize, or organize the record;

(b) the appellate court may tax the cost of preparing transcripts and copies for the record:

(i) against a party who unreasonably refuses to stipulate to shorten, summarize, or organize the record; or

(ii) according to any other provision of law.

(4) The appellate court shall grant relief only if, on the basis of the agency's record, it determines that a person seeking judicial review has been substantially prejudiced by any of the following:

(a) the agency action, or the statute or rule on which the agency action is based, is unconstitutional on its face or as applied;

(b) the agency has acted beyond the jurisdiction conferred by any statute;

(c) the agency has not decided all of the issues requiring resolution;

(d) the agency has erroneously interpreted or applied the law;

(e) the agency has engaged in an unlawful procedure or decision-making process, or has failed to follow prescribed procedure;

History: L. 1951, ch. 58, § 1; C. 1943, Supp., 104-2-1; L. 1969, ch. 247, § 1; 1986, ch. 47, § 40; 1988, ch. 248, § 4; 1990, ch. 80, § 4.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, in Subsection (2), rewrote the second sentence which read "Thereafter, the term of office of a justice of the Supreme Court is ten years and until his successor is appointed and approved in accordance with Section 20-1-7.1" and, in Subsection (6), substituted "determines" for "decides" at the end of the fourth sentence.

The 1990 amendment, effective April 23, 1990, deleted "next" after "January" and made punctuation changes in Subsection (2); deleted "not" following "chief justice may" in the third sentence of Subsection (3); deleted "additional" before "duties" in Subsection (5); deleted "where not inconsistent with the law" following "chief justice" and added "as consistent with the law" at the end of Subsection (6).

Cross-References. — Chief justice, Utah Const., Art. VIII, Sec. 2.

Disqualification in particular case, Utah Const., Art. VIII, Sec. 2.

Judicial nomination and selection, § 20-1-7.1 et seq.

Membership on state law library board, § 37-1-1.

Proceedings unaffected by vacancy, § 78-7-21.

Qualifications of justices, Utah Const., Art. VIII, Sec. 7.

Retirement, Utah Const., Art. VIII, Sec. 15; § 49-6-101 et seq., §§ 78-7-29, 78-7-30.

Salary, Utah Const., Art. VIII, Sec. 14.

COLLATERAL REFERENCES

Am. Jur. 2d. — 20 Am. Jur. 2d Courts §§ 67, 68.

C.J.S. — 21 C.J.S. Courts § 111 et seq.; 48A C.J.S. Judges §§ 3, 7, 8, 21 to 25, 85.

Key Numbers. — Courts ⇐ 101, 248; Judges ⇐ 1, 7 to 12.

78-2-1.5, 78-2-1.6. Repealed.

Repeals. — Section 78-2-1.5 (L. 1969, ch. 225, § 2), relating to salaries of Supreme Court justices, was repealed by Laws 1971, ch. 182, § 4.

Section 78-2-1.6 (L. 1979, ch. 134, § 1; 1981, ch. 150, § 1), relating to salaries of justices, was repealed by Laws 1981, ch. 267, § 2, effective July 1, 1982.

78-2-2. Supreme Court jurisdiction.

(1) The Supreme Court has original jurisdiction to answer questions of state law certified by a court of the United States.

(2) The Supreme Court has original jurisdiction to issue all extraordinary writs and authority to issue all writs and process necessary to carry into effect its orders, judgments, and decrees or in aid of its jurisdiction.

(3) The Supreme Court has appellate jurisdiction, including jurisdiction of interlocutory appeals, over:

(a) a judgment of the Court of Appeals;

(b) cases certified to the Supreme Court by the Court of Appeals prior to final judgment by the Court of Appeals;

(c) discipline of lawyers;

(d) final orders of the Judicial Conduct Commission;

(e) final orders and decrees in formal adjudicative proceedings originating with:

(i) the Public Service Commission;

(ii) the State Tax Commission;

(iii) the Board of State Lands and Forestry;

(iv) the Board of Oil, Gas, and Mining; or

(v) the state engineer;

(f) final orders and decrees of the district court review of informal adjudicative proceedings of agencies under Subsection (e);

(g) a final judgment or decree of any court of record holding a statute of the United States or this state unconstitutional on its face under the Constitution of the United States or the Utah Constitution;

(h) interlocutory appeals from any court of record involving a charge of a first degree or capital felony;

(i) appeals from the district court involving a conviction of a first degree or capital felony; and

(j) orders, judgments, and decrees of any court of record over which the Court of Appeals does not have original appellate jurisdiction.

(4) The Supreme Court may transfer to the Court of Appeals any of the matters over which the Supreme Court has original appellate jurisdiction, except:

(a) capital felony convictions or an appeal of an interlocutory order of a court of record involving a charge of a capital felony;

(b) election and voting contests;

(c) reapportionment of election districts;

(d) retention or removal of public officers;

(e) general water adjudication;

(f) taxation and revenue; and

(g) those matters described in Subsection (3)(a) through (f).

(5) The Supreme Court has sole discretion in granting or denying a petition for writ of certiorari for the review of a Court of Appeals adjudication, but the Supreme Court shall review those cases certified to it by the Court of Appeals under Subsection (3)(b).

(6) The Supreme Court shall comply with the requirements of Title 63, Chapter 46b, in its review of agency adjudicative proceedings.

History: C. 1953, 78-2-2, enacted by L. 1986, ch. 47, § 41; 1987, ch. 161, § 303; 1988, ch. 248, § 5; 1989, ch. 67, § 1.

Repeals and Reenactments. — Laws 1986, ch. 47, § 41 repeals former § 78-2-2, as enacted by Laws 1951, ch. 58, § 1, relating to original appellate jurisdiction of Supreme Court, and enacts the above section.

Amendment Notes. — The 1988 amendment, effective April 25, 1988, substituted "formal adjudicative proceedings" for "cases" in Subsection (3)(e); added Subsection (3)(f); redesignated former Subsections (3)(f) to (3)(i) accordingly; substituted "(i)" for "(h)" at the end of Subsection (4)(g); and made minor stylistic changes.

The 1989 amendment, effective April 24, 1989, added "and Forestry" at the end of Subsection (3)(e)(iii); rewrote Subsection (4)(a) which read "first degree and capital felony convictions"; substituted "(f)" for "(i)" at the end of Subsection (4)(g), and made minor stylistic changes.

Cross-References. — Appeals from juvenile courts, § 78-3a-51.

Appeals in criminal cases, U R.Cr.P. 26.

Chief justice to preside over impeachment of governor, § 77-5-2.

Election contest appeals, §§ 20-3-35, 20-15-14.

Extraordinary writs, Utah Const. Art. VIII, Sec. 3; U.R.C.P. 65B.

Industrial commission orders, review of, § 35-1-36.

Jurisdiction, Utah Const., Art. VIII, Sec. 3.

State bar, promulgation of rules, review of disciplinary orders, §§ 78-51-14, 78-51-19.

Unemployment compensation decisions, review of, § 35-4-10.

NOTES TO DECISIONS

ANALYSIS

Habeas corpus proceedings.
Post-conviction review.
Scope.
—Sentence reduction.
Cited.

Habeas corpus proceedings.

The language of Subsection (2)(g) is sufficiently broad to include those cases where a criminal conviction is involved in a habeas corpus proceeding challenging extradition. Hernandez v. Hayward, 764 P.2d 993 (Utah Ct. App. 1988).

The Court of Appeals lacked original appellate jurisdiction of an appeal from the denial of an extraordinary writ involving an interstate transfer of a prisoner which bore no relation to his underlying criminal conviction, except that "but for" the conviction, he would not have been incarcerated in Arizona and then transferred to Utah. Ellis v. DeLand, 783 P.2d 559 (Utah Ct. App. 1989).

Appeal from the denial of a petition for writ of habeas corpus was properly before the Court of Appeals, where the writ challenged the post-conviction actions of the board of pardons and did not challenge the conviction in the trial court or the sentence, and the fact that defendant was serving a sentence for a first-degree felony did not require a transfer to the Supreme Court under the circumstances. Northern v. Barnes, 814 P.2d 1148 (Utah Ct. App. 1991).

Post-conviction review.

Post-conviction review may be used to attack a conviction in the event of an obvious injustice or a substantial and prejudicial denial of a constitutional right in the trial. Gomm v. Cook, 754 P.2d 1226 (Utah Ct. App. 1988).

Scope.

This statute defines the outermost limits of appellate jurisdiction, allowing the Court of Appeals to review agency decisions only when the legislature expressly authorizes a right of review. It is not a catchall provision authorizing the court to review the orders of every administrative agency for which there is no statute specifically creating a right to judicial review. DeBry v. Salt Lake County Bd. of Appeals, 764 P.2d 627 (Utah Ct. App. 1988).

—Sentence reduction.

When a conviction is reduced under § 76-3-402, the appeal lies in the court having jurisdiction of the degree of crime recorded in the judgment of conviction and for which defendant is sentenced, rather than the degree of crime charged in the information or found in the verdict. State v. Doung, 813 P.2d 1168 (Utah 1991).

Cited in Scientific Academy of Hair Design, Inc. v. Bowen, 738 P.2d 242 (Utah Ct. App. 1987); In re Topik, 761 P.2d 32 (Utah Ct. App. 1988); State v. Humphrey, 794 P.2d 496 (Utah Ct. App. 1990); Johanson v. Fischer, 808 P.2d 1083 (Utah 1991); Heinecke v. Department of Commerce, 810 P.2d 459 (Utah Ct. App. 1991).

COLLATERAL REFERENCES

Utah Law Review. — Recent Developments in Utah Law — Judicial Decisions — Constitutional Law, 1990 Utah L. Rev. 129.

78-2a-4. Review of actions by Supreme Court.

Review of the judgments, orders, and decrees of the Court of Appeals shall be by petition for writ of certiorari to the Supreme Court.

History: C. 1953, 78-2a-4, enacted by L. 1986, ch. 47, § 47.

SOCIAL SECURITY AMENDMENTS OF 1965

For text of Act see p. 305

House Report (Ways and Means Committee) No. 213, Mar. 29, 1965
[To accompany H.R. 6675]
Senate Report (Finance Committee) No. 404, June 30, 1965
[To accompany H.R. 6675]
Conference Report No. 682, July 26, 1965 [To accompany H.R. 6675]
Cong. Record Vol. 111 (1965)

DATES OF CONSIDERATION AND PASSAGE

House Apr. 8, July 27, 1965

Senate July 9, July 28, 1965

The Senate Report and the Conference Report are set out.

SENATE REPORT NO. 404

THE Committee on Finance, to whom was referred the bill (H.R. 6675) to provide a hospital insurance program for the aged under the Social Security Act with a supplementary health benefits program and an expanded program of medical assistance, to increase benefits under the old-age, survivors, and disability insurance system, to improve the Federal-State public assistance programs, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill do pass.

PART I

I. BRIEF SUMMARY

The overall purpose of H.R. 6675 is as follows:

First, to provide a coordinated approach for health insurance and medical care for the aged under the Social Security Act by establishing three new health care programs: (1) a compulsory hospital-based program for the aged; (2) a voluntary supplementary plan to provide physicians' and other supplementary health services for the aged; and (3) an expanded medical assistance program for the needy and medically needy aged, blind, disabled, and families with dependent children.

Second, to expand the services for maternal and child health, crippled children, child welfare, and the mentally retarded, and to establish a 5-year program of "special project grants" to provide comprehensive health care and services for needy children (including those who are emotionally disturbed) of school age or preschool age.

6. IMPROVEMENT AND EXTENSION OF KERR-MILLS MEDICAL ASSISTANCE PROGRAM

(a) Background

The provision of medical care for the needy has long been a responsibility of the State and local public welfare agencies. In recent years, the Federal Government has assisted the States and localities in carrying this responsibility by participating in the cost of the care provided. Under the original Social Security Act, it was possible for the States, with Federal help, to furnish money to the needy with which they could buy the medical care they needed. Since 1950, the Social Security Act has authorized participation in the cost of medical care provided in behalf of the needy aged, blind, disabled, and dependent children—the so-called vendor payments.

Several times since 1950, the Congress has liberalized the provisions of law under which the States administer the State-Federal program of medical assistance for the needy. The most significant enactment was in 1960 when the Kerr-Mills medical assistance for the aged program was authorized. This legislation offers generous Federal matching to enable the States to provide medical care in behalf of aged persons who have enough income for their basic maintenance but not enough for medical care costs. This program has grown to the point where 40 States and 4 other jurisdictions have such a program and over 246,000 aged were aided in March 1965. Furthermore, medical care as a part of the cash maintenance assistance programs has also grown through the years until, at this time, nearly all the States make vendor payments for some items of medical care for at least some of the needy.

The committee bill is designed to liberalize the Federal law under which States operate their medical assistance programs so as to make medical services for the needy more generally available. To accomplish this objective, the committee bill would establish, effective January 1, 1966, a new title in the Social Security Act—"Title XIX: Grants to the States for Medical Assistance Programs."

Under the House bill, after an interim period ending June 30, 1967, all States would have to adopt the new program or lose Federal matching as to vendor medical payments since the current provisions of law would expire at that time. Under the committee bill the States will have the option of participating under the new program or continuing to operate under the vendor payment provisions of title I (old-age assistance and medical assistance for the aged), title IV (aid to families with dependent children), title X (aid to the blind), title XIV (aid to the permanently and totally disabled), and title XVI (the combined adult program). Programs of vendor payments for medical care will continue, as now, to be optional with the States.

(b) State plan requirements

(1) Standard provisions

The provisions in the proposed title XIX contain a number of requirements for State plans which are either identical to the existing provisions of law or are merely conforming changes. These are:

That a plan shall be in effect in all political subdivisions of the State.

That there shall be provided an opportunity for a fair hearing for any individual whose claim for assistance is denied or not acted upon with reasonable promptness.

That the State agency will make such reports as the Secretary may from time to time require.

That there shall be safeguards provided which restrict the use or disclosure of information concerning applicants or recipients to purposes directly connected with the administration of the plan.

That all individuals wishing to make application for assistance under the plan shall have an opportunity to do so and that such assistance shall be furnished with reasonable promptness.

That in determining whether an individual is blind there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select.

That medical assistance will be furnished to individuals who are residents of the State but who are absent therefrom.

(2) Additions to standard provisions

In addition to the requirements for State plans mentioned above, the committee bill contains several other plan requirements which are either new or changed over provisions currently in the law.

The bill provides that there shall be financial participation by the State equal to not less than 40 percent of the non-Federal share of the expenditures under the plan and that, effective July 1, 1970, the financial participation by the State shall equal all the non-Federal share. This provision was included to make certain that the lack of availability of local funds for financing of any part of the program not affect the amount, scope, or duration of benefits or the level of administration set by the State. Prior to the 1970 date, the committee will be willing to consider other legislative alternatives to the provisions making the entire non-Federal share a responsibility of the State so long as these alternatives, in maintaining the concept of local participation, assure a consistent statewide program at a reasonable level of adequacy.

The bill contains a provision found in the other public assistance titles of the Social Security Act that the State plan must include such methods of administration as are found by the Secretary to be necessary for the proper and efficient operation of the plan, with the addition of the requirement that such methods must include provisions for utilization of professional medical personnel in the administration of the plan. It is important that State utilize a sufficient number of trained and qualified personnel in the administration of the program including both medical and other professional staff.

The committee's bill would add a requirement that the State plan include a description of the standards, methods, and administrative arrangements which affect quality of medical care that a State will use in administering medical assistance. This amendment would give no authority to the Department of Health, Education, and Welfare with respect to the content of such standards and methods. In this respect it is somewhat analogous to the requirement, which has been in the public assistance titles since 1950 and which is included in the new title XIX, requiring States to have an authority or authorities responsible for establish-

ing and maintaining standards for private or public institutions in which recipients may receive care or services.

The committee also added an amendment to require that, after June 30, 1967, private and public medical institutions must meet standards (which may be in addition to the standards prescribed by the State) relating to protection against fire and other hazards to the health and safety of individuals, which are established by the Secretary of Health, Education, and Welfare. The committee assumes that the standards prescribed by many States at the present time will meet or exceed those prescribed by the Secretary.

The House bill provided that the State or local agency administering the State plan under title XIX shall be the same agency which is currently administering either title I (old-age assistance) or that part of title XVI (assistance for the aged, blind, and the disabled, and medical assistance for the aged) relating to the aged. Where the program relating to the aged is State supervised, the same State agency shall supervise the administration of title XIX.

The committee believes that the States should be given the opportunity to select the agency they wish to administer the program. A number of witnesses appearing before the committee have expressed the belief that the State health agency should be given the primary responsibility under this program. The committee bill leaves this decision wholly to the States with the sole requirement that the determination of eligibility for medical assistance be made by the State or local agency administering State plans approved under title I or XVI. The committee agrees with the statement in the House report that the welfare agencies have "long experience and skill in determination of eligibility."

The committee bill also provides that if, on January 1, 1965, and on the date a State submits its title XIX plan, the State agency administering or supervising the administration of the State plan for the blind under title X or title XVI of the Social Security Act is different from the State agency administering or supervising the administration of the new program, such blind agency may be designated to administer or supervise the administration of the portion of the title XIX plan which relates to blind individuals. This would include the eligibility determining function. In such case, the portion of the title XIX plan administered or supervised by each agency shall be regarded as a separate plan.

Current provisions of law requiring States to have an agency or agencies responsible for establishing and maintaining standards for the types of institutions included under the State plan have been continued under the bill. Your committee expects that these provisions will be used to bring about progressive improvement in the level of institutional care and services provided to recipients of medical assistance. Standards of care in many medical institutions are not now at a satisfactory level and it is hoped that current standards applicable to medical institutions will be improved by the State's standard-setting agency and that these standards will be enforced by the appropriate State body.

Under provisions of the committee bill, the State plan must include such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and that such care and services will be provided, in a manner consistent with simplicity of ad-

ministration and the best interests of the recipient. This provision was included in order to provide some assurance that the States will not use unduly complicated methods of determining eligibility which have the effect of delaying in an unwarranted fashion the decision on eligibility for medical assistance or that the States will not administer the provisions for services in a way which adversely affects the availability or the quality of the care to be provided. The committee expects that under this provision, the States will be eliminating unrewarding and unproductive policies and methods of investigation and that they will develop such procedures as will assure the most effective working relationships with medical facilities, practitioners, and suppliers of care and service in order to encourage their full cooperation and participation in the provision of services under the State plan.

The committee hopes that there will be continuing evaluation of all State plan requirements in relation to the basic objectives of the legislation.

(c) Eligibility for medical assistance

Under the committee bill, a State plan to be approved must include provision for medical assistance for all individuals receiving aid or assistance under State plans approved under titles I, IV, X, XIV, and XVI. It is only if this group is provided for that States may include medical assistance to the less needy.

Under the committee bill, medical assistance made available to persons receiving assistance under title I, IV, X, XIV, or XVI must not be less in amount, duration, or scope than that provided for persons receiving aid under any other of those titles. In other words, the amount, duration, and scope of medical assistance made available must be the same for all such persons. This will assure comparable treatment for all of the needy aided under the federally aided categories of assistance.

The bill provides furthermore that as States extend their programs to include assistance for persons who come within the various categories of assistance except that their income and resources are sufficient to meet their needs for maintenance, the medical assistance given such individuals shall not be greater in amount, duration, or scope than that made available for persons who are recipients of money payments. This was included in order to make sure that the most needy in a State receive no less comprehensive care than those who are not as needy.

Under the bill, if a State extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs. Thus, the income and resources limitation for the aged must be comparable to that set for the disabled and blind and must also have a comparability for that set for families with children who, except for their income and resources, would be eligible for AFDC. The scope, amount, and duration of medical assistance available to each of these groups must be equal.

The committee has amended the House bill, however, so that this provision as to comparability does not apply in the case of services in institutions for tuberculosis or mental diseases. Federal financial participa-

tion is authorized only with respect to recipients aged 65 and over in mental and tuberculosis institutions so it would not be appropriate to include them within the scope of this provision.

(d) Determination of need for medical assistance

The committee bill would make more specific a provision now in the law that in determining eligibility for and the extent of aid under the plan, States must use reasonable standards consistent with the objectives of the titles. Although States may set a limitation on income and resources which individuals may hold and be eligible for aid, they must do so by maintaining a comparability among the various categorical groups of needy people. Whatever level of financial eligibility the State determines to be that which is applicable for the eligibility of the needy aged, for example, shall be comparable to that which the State sets to determine the eligibility for the needy blind and disabled; and must also have a comparability to the standards used to determine the eligibility of those who are to receive medical assistance as needy children and the parents or other relatives caring for them.

Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary), are actually available to the applicant or recipient and as would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him. Income and resources taken into account, furthermore, must be reasonably evaluated by the States. These provisions are designed so that the States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available. Examples of income assumed include support orders from absent fathers, which have not been paid or contributions from relatives which are not in reality received by the needy individual.

The committee has heard of hardships on certain individuals by requiring them to provide support and to pay for the medical care needed by relatives. The committee believes it is proper to expect spouses to support each other and parents to be held accountable for the support of their minor children and their blind or permanently and totally disabled children even though 21 years of age or older. Such requirements for support may reasonably include the payment by such relative, if able, for medical care. Beyond such degree of relationship, however, requirements imposed are often destructive and harmful to the relationships among members of the family group. Thus, States may not include in their plans provisions for requiring contributions from relatives other than a spouse or the parent of a minor child or children over 21 who are blind or permanently and totally disabled. Any contributions actually made by relatives or friends, or from other sources, will be taken into account by the State in determining whether the individual applying for medical assistance is, in fact, in need of such assistance.

The bill also contains a provision designed to correct one of the weaknesses identified in the medical assistance for the aged program. Under the current provisions of Federal law, some States have enacted pro-

grams which contain a cutoff point on income which determines the financial eligibility of the individual. Thus, an individual with an income just under the specified limit may qualify for all of the aid provided under the State plan. Individuals, however, whose income exceeds the limitation adopted by the State are found ineligible for the medical assistance provided under the State plan even though the excess of the individual's income may be small when compared with the cost of the medical care needed. In order that all States shall be flexible in the consideration of an individual's income, the committee bill requires that the State's standards for determining eligibility for and extent of medical assistance shall take into account, except to the extent prescribed by the Secretary, the cost—whether in the form of insurance premiums or otherwise—incurred for medical care or any other type of remedial care recognized under State law. Thus, before an individual is found ineligible for all or part of the cost of his medical needs, the State must be sure that the income of the individual has been measured in terms of both the State's allowance for basic maintenance needs and the cost of the medical care he requires.

This determination must be made by the agency administering the old-age assistance or combined adult program; i.e., the welfare agency.

The State may require the use of all the excess income of the individual toward his medical expenses, or some proportion of that amount. In no event, however, with respect to either this provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income or resources which would bring the individual's income below the amount established as the test of eligibility under the State plan. Such action would reduce the individual below the level determined by the State as necessary for his maintenance.

The bill contains several interrelated provisions which prohibit or limit the imposition of any deduction, cost sharing, or similar charge, or of any enrollment fee, premium, or similar charge, under the plan.

No deduction, cost sharing or similar charge may be imposed with respect to inpatient hospital services furnished under the plan. This provision is related to another provision in the bill which requires States to pay reasonable costs for inpatient hospital services provided under the plan. Taken together, these provisions give assurance that the hospital bill incurred by a needy individual shall be paid in full under the provisions of the State plan for the number of days covered and that States may not expect to require the individual to use his income or resources (except such income as exceeds the State's maintenance level) toward that bill. The reasonable cost of inpatient hospital services shall be determined in accordance with standards approved by the Secretary and included in the State plan.

For any other items of medical assistance furnished under the plan, a charge of any kind may be imposed only if the State so chooses, and the charge must be reasonably related to the recipient's income or his income and resources. The same limitations apply in the case of any enrollment fee, premium, or similar charge imposed with respect to inpatient hospital services. The Secretary is given authority to issue standards under this

provision, which it is expected will protect the income and resources an individual has which are necessary for his nonmedical needs.

The hospital insurance benefit program included under other provisions of the bill provides for a deductible which must be paid in connection with the individual's claim for hospitalization benefits. The committee is concerned that hospitalization be readily available to needy persons and that the necessity of their paying deductibles or cost sharing shall not be a hardship on them or a factor which may prevent their receiving the hospitalization they need. For this reason, the committee's bill provides that the States make provisions, for individuals 65 years or older who are included in the new plan, of the cost of any deductible or cost sharing imposed with respect to individuals under the program established by the hospital insurance provisions of the bill.

A State medical assistance plan may provide for the payment in full of any deductibles or cost sharing under the insurance program established by part B of title XVIII. In the event, however, the State plan provides for the individual to assume a portion of such costs, such portion shall be determined on a basis reasonably related to the individual's income, or income and resources and in conformity with standards issued by the Secretary. The Secretary is authorized to issue standards—under this provision which, it is expected, will protect the income and resources of the individual needed for his maintenance—to guide the States. Such standards shall protect the income and resources of the individual needed for his maintenance and provide assurance that the responsibility placed on individuals to share in the cost shall not be an undue burden on them.

Titles I and XVI authorizing the medical assistance for the aged program now provide that the States may not impose a lien against the property of any individual prior to his death on account of medical assistance payments except pursuant to a court judgment concerning incorrect payments, and prohibit adjustment or recovery for amounts correctly paid except from the estate of an aged person after his death and that of his surviving spouse. This provision, under the committee bill, has been broadened so that such an adjustment or recovery would be made only at a time when there is no surviving child who is under the age of 21 or who is blind or permanently and totally disabled.

(e) Scope and definition of medical services

"Medical assistance" is defined under the bill to mean payment of all or part of the cost of care and services for individuals who would if needy, be dependent under title IV, except for section 406(a)(2), and are under the age of 21, or who are relatives specified in section 406(b)(1) with whom the child is living, or who are 65 years of age and older, blind, or permanently and totally disabled, but whose income and resources are insufficient to meet all their medical care costs. The bill, as do current provisions of law, permits Federal sharing in the cost of medical care provided up to 3 months before the month in which the individual makes application for assistance. Thus, the scope of the program includes not only the aged, blind, disabled, and dependent children as defined in State plans, but also children under the age of 21 (and their caretaker relatives) who come within the scope of title IV, except for